

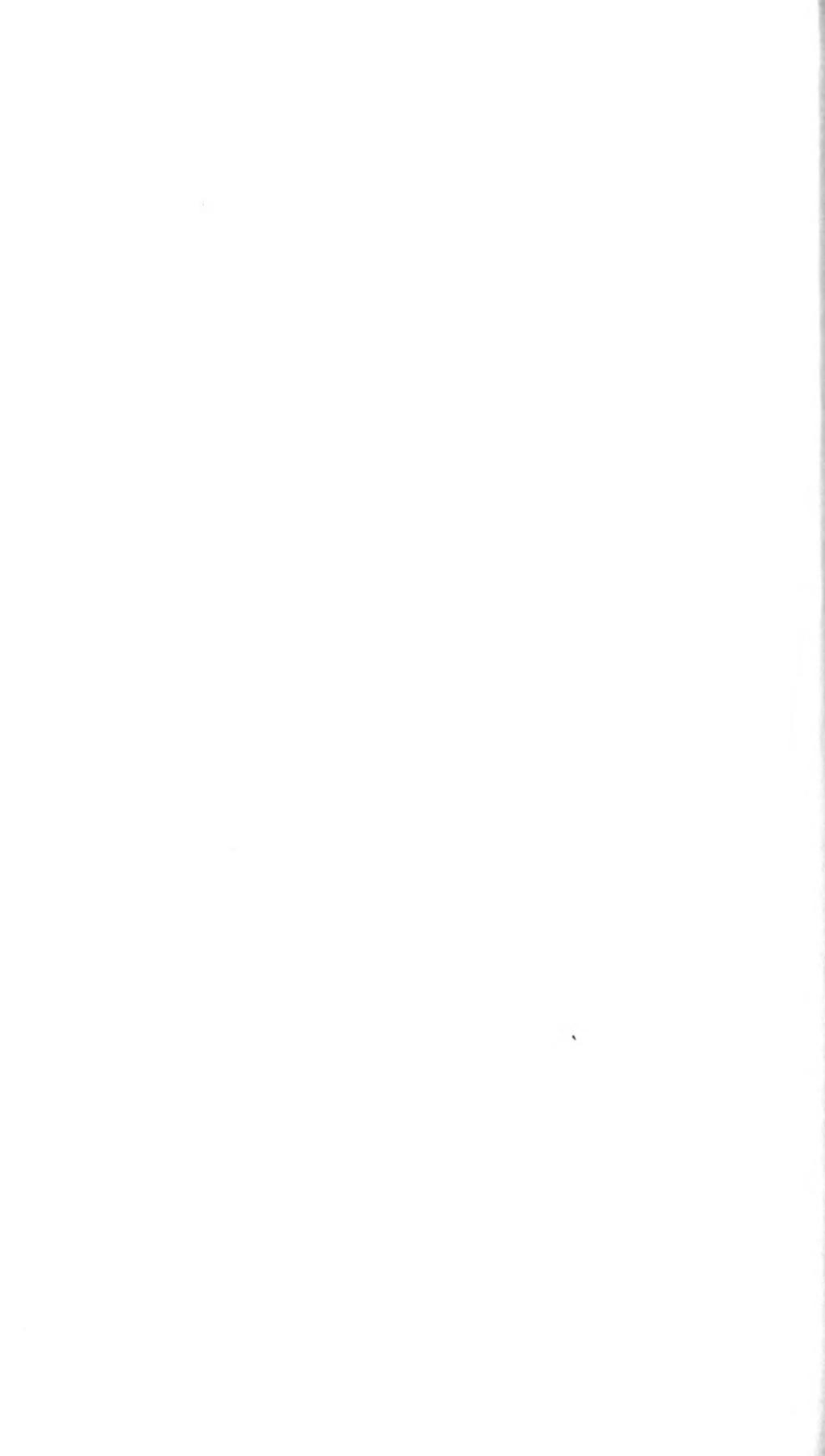
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THE

JANUARY 1969

DR. R. PAGE HUDSON JR.
First Chief Medical Examiner



Inside

THE HEALTH BULLETIN

First Published—April 1886

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The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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Editor: H. B. Rogers

Vol. 84 January 1969 No. 1

Cover: Dr. R. Page Hudson Jr. takes the oath of office as North Carolina's first chief medical examiner. He will direct the first statewide system for post-mortem medicolegal examinations.

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FDA Issues Warning About Artificial Sweeteners

The U. S. Food and Drug Administration has warned against the unrestricted use of cyclamates, the most commonly used artificial sweeteners.

FDA has issued a statement reflecting interim findings of the National Academy of Sciences, which conducted a review of the safety of artificial sweeteners.

An FDA spokesman said, "Our one concern is that children and adults not only drink artificially sweetened carbonated soft drinks but also consume many other products containing artificial sweeteners such as gum, candy, puddings, cookies, etc."

The text of the official FDA statement:

Many kinds of foods and drinks sweetened with sugar substitutes are now available in the stores. Because of this widespread and growing use, FDA sometime ago asked the National Academy of Sciences to review the safety of these artificial sweeteners.

An Academy Committee has now submitted an interim report advising that cyclamate sweeteners

should not be used in totally unrestricted amounts. Cyclamates are the most commonly used artificial sweeteners.

The Committee's recommendation was made because of questions scientists still have about the effects of the cyclamates. However, the Committee did say this: An adult can consume up to five grams of cyclamate a day without any probable hazard. Chil-

dren should use proportionately less. The smaller they are, the less they should use. The World Health Organization has recommended a daily limit based on weight. Its formula works out to a limit of about one and one-third grams of cyclamate a day for a 60-pound child.

Here's one way to translate that into practical terms: Artificially sweetened carbonated soft drinks—which account for most of the cyclamate consumption by the average consumer—contain from one-quarter to a little more than one gram of cyclamate in each 12-ounce bottle. □

How It Was In The Old North State

HOW TO SLEEP

Here are a few common sense directions guaranteed to be beneficial in ninety-five out of every one hundred cases of insomnia.

Get enough physical exercise during the day to tire you.

Go to bed at the first urgent invitation of Morpheus.

Be sure the bed is comfortable and the room is quiet.

Think pleasant thoughts.

Don't have the head of the bed lower than the foot.

Be sure there is no other livestock in the bed with you; if there are, change boarding houses.

If you haven't bathed lately, try a good application of soap and warm water just before retiring. This is said to work wonders in more directions than one.

If your neighbors' cats also have insomnia, throw them a few Jackson crackers. If this fails, a shotgun is known to be a sure remedy.

Eat supper at least two hours before retiring. Eat a light supper and take nothing indigestible.

Don't worry and don't take dope.

If you don't get to sleep right away and if you don't sleep quite as much as you think you should, remember that even lying awake in bed is very restful.

—*The Health Bulletin*, Vol. XXX, No. 3,

June 1915



Dr. Hudson (right) checks a point with Associate Justice Susie Sharp of the State Supreme Court following swearing-in ceremony. Justice Sharp administered the oath of office to the new chief medical examiner.

North Carolina Gets Chief Medical Examiner

"I shall not be sparing of myself or others in an effort to seek the truth and contribute to justice."

With these words, Dr. R. Page Hudson Jr. took office as North Carolina's first chief medical examiner.

Associate Justice Susie Sharp of the North Carolina State Supreme Court administered the oath of office at ceremonies December 6, 1968 in Raleigh.

On the platform with Dr. Hudson and Justice Sharp were Dr. Jacob Koomen, State health director, and State Senator John J. Burney of Wilmington, author of the bill passed by the 1967 North Carolina General

(Continued on page 8)



State Senator John J. Burney of Wilmington wrote the legislation enacted by the 1967 General Assembly creating North Carolina's first statewide medical examiner system.

Physical Therapy Assistant: A New Health Career in North Carolina

BY NANCY L. DUCKETT

*Public Information Officer
Department of Community Colleges*

An educational program to train people to become physical therapy assistants is now available for the first time in North Carolina. The pilot program is being offered by Central Piedmont Community College in Charlotte.

According to Robert L. Gossett, director of the Central Piedmont physical therapy assistant program, there are 11 students already enrolled in the six-quarter course, which began at the community college early in October.

Even though all of the students presently enrolled are women, Mr. Gossett points out that the program is most desirable for men, too.

To be admitted into the program, a student must be a high school graduate or he must have earned a high school equivalency certificate.

Mr. Gossett explained that the physical therapy assistant curriculum is made up of general college courses and technical offerings. So that the students are able to practice what they are taught at the community college, they spend time away from the school in clinical areas. "This will begin mid-way through the second quarter," said Mr. Gossett.

In no way should the physical therapy program, which leads to an associate in applied science degree, be confused

with those programs designed to prepare a person to become a physical therapist. A physical therapist must have, at the minimum, a baccalaureate degree. In addition, to meet the standards for qualification of the American Physical Therapy Association (APTA), a person must be licensed or registered by the state when licensure laws are applicable.

The American Physical Therapy Association recently adopted a policy statement supporting the training and utilization of the physical therapy assistant. This resulted from the current inability of established programs for the education of physical therapists to produce numbers of professionals to meet the growing health needs, coupled with the realization that many patient care needs can be met by a type of worker who has formal training at the technical level.

The 1967 policy statement defines the physical therapy assistant as "a skilled technical health worker who has completed an educational program approved by the association."

The statement continues to explain that "such an individual functions to assist the qualified physical therapist in patient related activities. The

degree of assistance depends, in part, upon the type of physical therapy service in which the assistant is employed and upon the health needs of the patient."

Also, "He [the physical therapy assistant] is capable of performing routine treatment procedures in accordance with planned programs and of assisting the qualified physical therapist in carrying out complex procedures and programs. The physical therapy assistant works within a physical therapy service administered by a qualified physical therapist who meets the standards of APTA. The assistant performs his duties with direction and supervision of the physical therapist to whom he is directly responsible."

Programs for the education of the physical therapy assistant are being established in many areas of the nation. In North Carolina, the State Advisory Committee for the education of the physical therapy assistant was formed in 1967 by the Department of Community Colleges at the request of the State Physical Therapy Association. This committee is made up of physical therapists and others interested in providing better and more complete health care. □

In 1967 the laboratory division of the North Carolina State Board of Health was requested to distribute 84,690 doses of typhoid vaccine. The year before that, 82,220 doses were distributed.

There were five new cases of typhoid in North Carolina in 1967.

Typhoid immunization is indicated only if there is household contact with a known typhoid carrier, or if there is a common-source outbreak in a community, or if a person is traveling to a foreign country.

THE HEALTH BULLETIN

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Printed by The Graphic Press, Inc., Raleigh, N. C.

Chief Medical Examiner (Continued from page 5)

Assembly creating the state-wide medical examiner system.

Among the 100 persons looking on were members of Dr. Hudson's family, colleagues from the campus of the University of North Carolina at Chapel Hill, and associates from the State Board of Health administrative staff.

The office of chief medical examiner, a function of the State Board of Health, is housed on the university campus. It will operate in close collaboration with the UNC School of Medicine.

Dr. Hudson recognized the oath-taking ceremony as a tribute to the extended concern for people by state and local governments in North Carolina, to determined cooperation of the

legal and medical professions, and to enlightened public opinion.

The medical examiner system, he said, will bring medical science and other sciences to the investigation of sudden, unexpected or unnatural deaths in North Carolina. There are some 9,000 such cases in the State each year.

He declared four objectives for the medical examiner program:

- protection of the innocent
- recognition of homicide and suicide
- unbiased medical evidence for criminal and civil courts
- identification of public health and industrial hazards.



February 1969

THE 1969 OFFICIAL
EASTER SEAL CHILD



THE HEALTH BULLETIN

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Cover: Three years ago, when she was four, Donna Kay Howell was crippled by a rare childhood stroke which left the right side of her body completely paralyzed. She couldn't stand or walk, and she had a problem with her speech.

Easter Seal Programs

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Now, Donna Kay is seven. She is making a remarkable recovery, thanks to the skill of doctors and the physical, occupational and speech therapists at the Easter Seal Rehabilitation Center in Tallahassee, Florida.

Donna Kay Howell is the 1969 official Easter Seal child. Her story is on page 5.

German Measles Vaccine Being Tested

One Test in North Carolina

By DR. JOHN D. HAMILTON

An effective vaccine for rubella—German measles—is now a very real possibility for the near future. And an experiment underway in North Carolina's Wake County is playing a major role in the developments.

With few other vaccines has the potential for prevention of serious consequences been so great as with the rubella vaccine now being tested.

Although a relatively inconsequential disease in itself, rubella may have devastating consequences for a pregnant woman—and for the child she is carrying.

For many years the causes of cataracts, deafness, congenital heart disease and mental retardation were not known. But in 1941 a doctor reported for the first time that cataracts in a newborn infant can follow

when the mother had German measles during pregnancy. In the years since that original report, the association of maternal rubella to the other conditions in newborn infants has been well documented.

In 1964-65 the United States was hit by an epidemic of rubella. Experts say some 10,000-20,000 infants may have been born with congenital malformations as a direct result of maternal infection.

The rubella virus was successfully cultivated in tissue culture in 1962. This opened the door to serologic studies — the groundwork in developing any vaccine. Soon afterwards, studies began on a vaccine prepared by two physicians at the National Institutes of Health.

Today, after several years of testing for both favorable and adverse effects, clinical trials of the Meyer - Parkman HPV-77 duck embryo vaccine are being conducted. One of the most ex-

Dr. Hamilton is Epidemiology Intelligence Service Officer for the North Carolina State Board of Health.

tensive trials has been undertaken in Wake County with the support of the Merck Institute for Therapeutic Research.

The North Carolina rubella trial started last September. Dr. Joseph Pagano of the Department of Medicine at the University of North Carolina at Chapel Hill and Dr. Richard Lipman of the Department of Pediatrics there directed and coordinated the project.

Cooperating and collaborating with these investigators were Dr. Millard Bethel and Dr. Jane Wooten of the Wake County Health Department and their entire staff. Full cooperation also came from superintendents, principals and teachers in the Raleigh city and Wake County schools. In addition there were volunteers from the North Carolina State Board of Health in Raleigh and North Carolina Memorial Hospital at Chapel Hill.

The trial has involved 63 schools in Wake County. Approximately 5,200 first and second graders received a dose of the live rubella vaccine. Their reactions were documented by daily fever records taken in the schools. Home records were kept by the parents.

Eight schools were involved in vaccine-serology studies. At these schools 671 families, including this same number of

mothers and 1,077 of their children between the ages of 4-9, received the vaccine or placebo (artificial harmless fluid), according to a pre-arranged schedule. Acute serum blood sample was taken and careful records kept on the patients. In November a follow-up blood sample was taken. Serologic evaluation of these patients will allow the investigators to determine and document the effectiveness of the vaccine in immunizing the children, and, at the same time, to measure the effectiveness of the vaccine in controlling the transmission of the disease from children to mothers. Any adverse reactions will be documented by home and school records.

The results of the Wake County trial will soon be available. Previous studies suggest that the immunologic response will be excellent, and transmissibility and adverse reactions absent. In addition, the trial has allowed the effective immunization of a large segment of Wake County's primary school population.

If all goes well, the results of the Wake County study and others underway in other places will lead to licensing of the rubella vaccine within a year—hopefully before the next large rubella epidemic, which is predicted in 1970. □

The 1969 Official Easter Seal Child

Donna Kay Howell



Donna Kay Howell, seven-years-old, of Tallahassee, Florida, has been named 1969 National Easter Seal Child. The campaign this year opens March 1 and continues to April 6.

The pretty little brunette, victim of a rare childhood stroke, will help launch the Easter Seal appeal and take a nationwide trip.

Hit by the stroke when she was four, Donna Kay suffered complete paralysis of the right side of her body. She was un-

able to stand or walk, and she had a problem with her speech.

After a three-week period of hospitalization, Donna Kay was referred to the Easter Seal Rehabilitation Center in Tallahassee. There, physical, occupational and speech therapists began working to help her overcome the crippling effects of the stroke.

Donna Kay made a full recovery from her speech defect after a month of treatment. She still receives physical and occupational therapy at the center once a week to correct a slight limp and restore full use of her right hand. Treatment includes muscle re-education, gait training and electrical stimulation to the wrist.

Donna Kay's father, Jack, is a draftsman and her mother, Opal, is a beautician. The couple has one other daughter, Janice Lynn, three-years-old.



Despite her handicap, Donna Kay is active, sometimes a tomboy, sometimes a demure young lady. She runs and plays with neighborhood children and when it comes to climbing trees, one of her favorite activities, she can out-shinny almost every boy in the neighborhood.

Donna Kay, a second grader in public school, is bright, alert and attentive in class.

Easter Seal affiliates in every state, Puerto Rico and Washington, D. C., provided direct treatment and other services to more than 253,000 crippled children and adults last year. Contributions made during the annual appeal are the major source of financing for 2,844 Easter Seal facilities and programs. □

Short Course For Nurses

A two-week short course for professional nurses who supervise personnel in cardiac units will be given three times in the coming year at the University of North Carolina at Chapel Hill.

The course, entitled *Scientific Approach to Supervision of Cardiac Units—Personnel, Patients and Practices*, will be offered through the Continuing Education Program of the UNC School of Nursing.

Federal traineeships are available.

Starting dates for the course this year are April 21 and November 3. A course will start February 2, 1970.

Further information is available from:

*Susanna L. Chase, Director
Continuing Education in Nursing
The University of North Carolina
at Chapel Hill
Chapel Hill, N. C. 27514*

Public Health Workers to Meet

The 1969 meeting of the Southern Branch of the American Public Health Association will be held May 21-23 in Oklahoma City, Oklahoma.

The 37th annual meeting of the organization is expected to attract public health workers from 16 states and the District of Columbia.

The theme of the meeting will be "The Seventies—Decade for Decision."

Keynote speaker will be Dr. Myron E. Wegman, dean of the School of Public Health at the University of Michigan. He will speak on "The Health Consumer—Needs and Wants."

World Health Day will be observed April 7, 1969. The day will mark the anniversary of the coming into force of the World Health Organization (WHO). The theme of World Health Day this year is "Health, Labor and Productivity."

Reportable Diseases

Communicable Disease Regulations Revised By State Board of Health

On the following four pages is a newly published summary of revised communicable disease regulations approved by the North Carolina State Board of Health last fall.

The new regulations mark the first general revision since 1944.

The main changes, according to Dr. J. N. MacCormack, consultant to the Communicable Disease Control Section of the State Board of Health, are in the isolation and quarantine regulations for individuals.

Copies of the summary are available upon request from the Communicable Disease Control Section, North Carolina State Board of Health, Post Office Box 2091, Raleigh, N. C. 27602. □

NORTH CAROLINA STATE BOARD OF HEALTH
SUMMARY OF REPORTABLE DISEASES AND COMMUNICABLE DISEASE REGULATIONS
(Revised through January 1, 1969)

(In addition to the diseases specified herein, cancer is also reportable)

DISEASE REQUIRED TO BE REPORTED	ISOLATION OF PATIENT	QUARANTINE OF CONTACTS
Amebiasis	Not required	Not required
Anthrax	Required until all lesions are bacteriologically free of anthrax bacilli	Not required
Aseptic meningitis	Required during febrile period	Not required
Brucellosis	Not required	Not required
Chancroid	Not required	Not required
Cholera	Required during communicable period	Personal surveillance required of contacts for 5 days from last exposure and longer if feces contains cholera vibrios
Dengue	Required to be screened or in quarters treated with insecticide with residual effect until sixth day after onset	Not required
Diphtheria	Required until 2 throat cultures & 2 nose cultures at 24-hour intervals after cessation of antibiotic therapy fail to show diphtheria bacilli or for 14 days	Modified quarantine required for all intimate contacts until nose and throat cultures are negative
Encephalitis Primary Post-infectious	Not required Not required	Not required Not required
Food intoxication Botulism Gastric Staphylococcal Other or unknown	Not required Not required Not required Not required	Not required Not required Not required Not required
Gonorrhea	Required until 24 hours after antibiotic treatment of gonococcal vulvovaginitis of children & <i>Neonatal</i> <i>Neonatorum</i>	Not required

Leprosy	Home isolation required as a minimum with avoidance of contact with young children	Not required
Leptospirosis	Not required	Not required
Lymphogranuloma Venereum	Not required	Not required
Malaria	Required to be screened for duration of fever	Not required
Measles (Rubeola)	Optional with health director	Not required
Meningococcal Infections	Required until 24 hours after starting chemotherapy	Not required--surveillance is profitable
Plague	Required for duration of the disease	Pneumonic plague contacts--quarantine required for six days with recording of body temperature every 4 hours and dusting with insecticide powder. All other contacts--surveillance required for six days and dusting with insecticide powder.
Poliomyelitis	Required for seven days	Not required
Psittacosis	Required during acute febrile stage	Not required
Q Fever	Not required	Not required
Rabies, Human	Required for duration of the disease	Not required
Rocky Mountain Spotted Fever	Not required	Not required
Salmonellosis	Exclusion from food handling and care of children required until 3 consecutive stool cultures are negative for <i>Salmonella</i> .	Family contacts not to be employed as food handlers during period of contact before three stool cultures at daily intervals are negative
Syphilis	Required during acute illness	Contacts not to be employed as food handlers during period of contact before three stool cultures at daily intervals are negative
Streptococcal Pharyngitis (including Scarlet Fever)	Required until 24 hours after initiation of penicillin therapy provided therapy is continued for seven to ten days	Not required
Smallpox	Required until all scabs have disappeared	Unvaccinated contacts--vaccination and quarantine required for sixteen days from date of last exposure. Contacts successfully vaccinated within previous 3 years--revaccination and surveillance required until height of reaction to vaccination has passed

DISEASE REQUIRED TO BE REPORTED	ISOLATION OF PATIENT	QUARANTINE OF CONTACTS
Syphilis	Not required	Not required
Tetanus	Not required	Not required
Trachoma	Not required	Not required
Trichinosis	Optional with health director	Optional with health director
Tuberculosis	Not required	Not required
Tularemia	Required in flyproof room until 3 consecutive fecal and urine cultures, taken at least 24 hours apart and not earlier than one month after onset, are negative	FAMILY contacts not to be employed as food handlers during period of contact nor before repeated negative fecal and urine cultures are obtained.
Typhus, Murine	Not required	Not required
Typhus, European (Louse-Borne)	Required until delousing of patient, clothing, living quarters, and household contacts has been achieved	Required of louse-infested contacts until application of insecticide with residual effect has been achieved
Whooping Cough	Separation from susceptible children and exclusion from school and public places for 21 days required	Exclusion of nonimmune children contacts from school and public gatherings for 14 days after last exposure required
Yellow Fever	Screening or spraying with residual-effect insecticide required during first 3 days	Not required

INSTRUCTIONS FOR REPORTING

1. Physicians and other persons are required to report these diseases as follows:

2. All reports of these diseases from persons required to report should be mailed within 24 hours after diagnosis and local health directors should forward these reports within 24 hours of receipt as follows:

Location of patient	At time of disease onset	At time of disease diagnosis	Method of reporting
N. C. city or county health department jurisdiction	Same N. C. city or county health department jurisdiction	All reportable communicable diseases except venereal diseases	All reportable venereal diseases (chancre, gonorrhea, granuloma inguinale, LGV, and syphilis)
Outside N. C.	N. C. city or county health department jurisdiction	Report to be sent by person diagnosing or suspecting disease to local health director of N. C. city or county in which patient is located at the time of disease diagnosis; health director to forward report to N. C. State Board of Health.	Report to be sent by person diagnosing or suspecting disease to local health director of N. C. city or county in which patient is located at the time of disease diagnosis; health director to forward original report to local health director in whose jurisdiction patient was residing at time of disease onset and duplicate report marked "copy" to be sent to N. C. State Board of Health; health director of city or county of patient's residence at time of disease onset to forward original report to N. C. State Board of Health.

*Although not required by regulation, it is suggested that a copy of the report be sent to the health director of the city or county in which the patient resided at the time of disease onset.

Adults and Children Are Beneficiaries of Easter Seal Programs



An elderly stroke patient gets help along the road to recovery by a physical therapist at an Easter Seal Center.

It has been half a century since the National Easter Seal Society, a voluntary organization that now serves almost a quarter of a million crippled children and adults annually, first extended its services to one crippled child in a hospital in Ohio.

The plight of the child, a boy who needed expensive surgery and therapy if he was to be able to stand and walk, came to the attention of Edgar F. Allen, an Elyria businessman whose own son had been injured in a streetcar collision and died for lack of emergency medical facilities.

Allen gave up his prosperous business, set about raising the necessary funds, and, in 1921, opened a hospital for crippled children.

The hospital was not an immediate success. Parents of crippled children were slow to risk public exposure in order to bring their children to the new hospital for treatment.

It took the patience and persistence of volunteers and public health nurses to seek out the children and persuade their parents to abandon their feelings of guilt and shame to get help for their offspring.



Easter Seal rehabilitation centers offer vocational training that can open the door to new life for accident victims by teaching them new trades.

As parental resistance was broken, the hospital's staff found itself deluged with requests for treatment.

Rotarians provided major support for the society's programs of medical and referral care for crippled children in the early days. They also did much to bring about legislation establishing state services for handicapped children.

But progress was slow. In 1924, three years after Allen founded the hospital, there were only 9,000 beds available in hospitals and other institutions to treat 289,000 children known to be suffering from congenital defects, cerebral palsy and crippling caused by tuberculosis and other conditions.

Five years later — in 1929 — there were 23 state crippled children's societies, operating largely through making direct payments for the care, treatment and education of crippled children and seeking legislation for them.

The National Society adopted Easter Seals as a fund raising device in 1934. That year, the Easter Seal appeal raised \$47,052. In 1967, its income was more than \$27 million.

An era of expansion began with the National Society's move to Chicago in 1944. With Easter Seal societies in various stages of development in 40 states, the national organization soon included state and local affiliates in the 50 states, the District of Columbia and Puerto Rico.

A national staff of professional consultants in care and treatment organization, public education and fund raising was developed to serve these affiliates and to formulate new national projects and programs. The society's treatment programs were extended and their emphasis changed to meet new health needs. Programs which formerly were centered around hospitals and convalescent care were redirected to rehabilita-

tion services at the community level.

Having established care and treatment and education programs in fulfillment of its objectives, the Society, in 1953, established the Easter Seal Research Foundation, realizing a third major objective.

Today, the Easter Seal Society, with its hundreds of state

and local affiliates, operating more than 2,000 facilities and programs, is the largest of its kind in the nation. Its affiliates offer help to handicapped children and adults through rehabilitation and treatment centers; clinics; camps; sheltered workshops; home employment; physical; occupational and speech therapy programs; and other related services. □

Physical therapy is an important first step toward rehabilitation for youngsters at Easter Seal centers.



Heart Acts as Thermostat for the Body

Your heart and blood play an important part in "thermal regulation," which helps keep you warm in cold weather and cool in hot weather, says the North Carolina Heart Association. Because the body's built-in thermostatic machinery takes time to adjust to weather extremes, you should be careful about jumping from one extreme to the other. Make the change gradually, if possible. Or, if you find yourself caught in a sudden change, try to rest before becoming active. This will give your body time to adjust to the different weather environment. □

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Medicare Premium Stays Same

The monthly premium older people pay for the voluntary medical insurance part of Medicare will remain at the present \$4 for the period July 1969 through June 1970.

The premium covers half the cost of protection that helps pay doctors' and surgeons' bills and a variety of other health care expenses. The other half is paid out of federal general revenues.

Robert A. Flynn, social security district administrator in Raleigh, said that 95 per cent of the population aged 65 and over are now enrolled in the supplementary medical insurance program. Participation is up from the 91 per cent enrolled when Medicare began July 1, 1966.

Flynn said a new enrollment period opened January 1, 1967 to provide another chance for people who missed out earlier to sign up for the medical insurance protection. For persons born on or before October 1, 1901, and for those who have been enrolled but dropped out before January 1, 1967, the new period will be the last chance to enroll.

Older people who delay in enrolling pay a premium that is 10 per cent higher for each full year they could have had the medical insurance protection but were not enrolled. And those who wait three years past their first chance to sign up cannot get the coverage at all. □

THE HEALTH BULLETIN
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Printed by The Graphic Press, Inc., Raleigh, N. C.

Research Triangle Park Facility Is Elevated

The National Institute of Environmental Health Sciences (NIEHS) in North Carolina's Research Triangle Park has been established as one of the National Institutes of Health.

The headquarters and research center of NIEHS operate under a budget of \$17.8 million for the current fiscal year. The facility, directed by Dr. Paul Kotin, is the only major component of NIH located away from the parent organization's campus at Bethesda, Md.

Scientists at the research center are working to identify harmful environmental agents, to determine the mechanisms

by which those agents affect an individual's health, and to develop data on the effects of long-term, low-level exposures.

NIEHS is also the hub for nationwide federal support of basic research and research training in the environmental health sciences.

Former HEW Secretary Wilbur J. Cohen said knowledge developed at the Research Triangle facility will provide a scientific base upon which measures can be developed to help control or prevent environmental health problems. He called this "a major priority for HEW." □



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

NORTH CAROLINA STATE BOARD OF HEALTH
OFFICE OF VITAL STATISTICS

Nº

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Binocular Jones

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North Carolina
Minor Ch

Defendant
Mercy Jones

Name Mercy J.
Residence or State North
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County
Date of Decree

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ATTENDANT

Tenes ^{12b} Jones
ADDRESS ^{12a}

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CITY, TOWN, OR LOCATION
STATE
MIDDLE
COUNTRY

4th Carolina

VITAL STATISTICS IN NORTH CAROLINA

LICENSE AND CERTIFICATE OF MARRIAGE
State of North Carolina

March, 1969

THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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JOHN ANDREWS, B.S., RALEIGH

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Editor: H. B. Rogers

Vol. 84 March 1969 No. 3

Cover: Certificate of live birth, license and certificate of marriage, certificate of fetal death, certified record of divorce decree granted, certificate of death: the documents that record the vital events of our lives. These are the makings of the Public Health Statistics Section of the North Carolina State Board of Health. Keeping tabs on the documents for millions of North Carolinians keeps Director Glenn Flinchum and his staff busy. Mr. Flinchum tells the story, starting on page 11.

Social Security's Disability Program

Disabled workers and their dependents can get financial help at the time they probably need it most. But they must know about the benefits and apply for them.

By ROBERT A. FLYNN

Disability, whether caused by injury or illness, can mean serious financial problems for any family. If your income stopped because of disability, would your family need help to meet the necessities of life?

Social security disability insurance benefits help replace lost income by paying monthly cash benefits when serious disability strikes.

Each year about 300,000 disabled workers and their families begin receiving social security disability benefits. In recent months about two of every three disabled workers who apply for benefits have been found eligible. Unfortunately, many disabled workers who could receive benefits do not apply for them, often because they do not know these benefits are available.

Four of every five men and women age 25-64 can count on receiving benefits in the event

Mr. Flynn is Raleigh district manager, Social Security Administration.

the breadwinner suffers a severe and prolonged disability.

This protection means that you can look to social security for financial help if you become severely disabled and cannot work. At a time when you would probably need help the most, social security disability benefits would be available to help you through the financial crisis.

What Is 'Disabled'?

Just what does "disabled" mean? Well, you're disabled if you have a physical or mental impairment which prevents you from doing substantial work and which has lasted (or is expected to last) twelve months or more. The payments can begin with the seventh month of disability. Monthly benefits continue as long as your disability prevents you from working.

Payments for a disabled worker now range from \$55 to \$204 a month, depending on his average earnings under social security. And if you start receiving benefits, your wife and children also may receive benefits as your dependents. Total family benefits can amount to as much as \$415.20 a month at this time.

A person who is over 31 when he becomes disabled can receive benefits if he has social security credit for five years of work in the ten years before he became

disabled.

Before 1968 the five-years-of-work rule applied to everyone. A change in the law early in 1968, however, reduced the amount of work credit needed by a worker disabled before 31. Now a worker who becomes disabled between 24 and 31 needs social security credit for only half the time between 21 and the beginning of his disability. Workers disabled before 24 need one and one-half years' credit in the three-year period before the disability begins.

Dependent's Benefits

There are two other important types of social security disability payments; both go to dependents of workers after the worker has started receiving retirement or disability benefits or has died. These are benefits for adults disabled before 18 who continue to be disabled after 18, and benefits at 50 or later for disabled widows. Disabled widowers who were dependent on their wives for support can also get benefits under this part of the law, as can some former wives who had been divorced but who were still receiving support from their former husbands.

Disabled widows 50-60 can get benefits based on their spouse's social security record only if they become disabled before the worker's death or with-

in seven years after his death. However, if a widow received social security benefits as a mother with children, she can get disabled widow's payments if she becomes disabled before those payments end or within seven years after they end.

The seven-year period is intended to give her an opportunity to work long enough under social security to receive social security disability benefits on her own earnings.

Childhood Disability Benefits

A person who was disabled before 18 and has not married can get benefits based on the earnings of either of his parents. The payments begin at the time the parent covered under social security retires, becomes disabled, or dies.

Each year about 25,000 people begin to receive these "childhood disability" benefits. Some of them are in their fifties and sixties at the time benefits begin.

A disabled widow, widower, or divorced wife may be considered disabled only if she or he has an impairment so severe that it would ordinarily prevent a person from working. Other factors such as age, education, and work experience may be considered in determining whether a worker is disabled but are not considered for these survivors.

At 62 a widow receives 82.5 per cent of her deceased husband's retirement benefit. If she starts receiving widow's disability benefits at an earlier age, she gets a permanently reduced amount.

The amount depends on what the husband's retirement benefits would have been had he been 65 at the time of his death and how old the widow is at the time benefits begin. For example, if a widow starts to get benefits at 50, she receives 50 per cent of her husband's benefit (figured as though he was 65 at death). At 55 she receives about 60.75 per cent of the husband's amount. At 58, it is about 67 per cent.

Objective Is Self-Support

A major objective of the social security disability program is to encourage disabled persons to undertake rehabilitation programs and to become self-supporting.

All disability applicants are considered for vocational rehabilitation services whether or not their claims are approved. The services are provided by State vocational rehabilitation agencies—usually at no cost to the disabled person. The agencies provide vocational counseling training and help in finding a job, and medical services and supplies.

State vocational rehabilita-

tion agencies have so far reported about 100,000 disability claimants successfully rehabilitated. Since the program began, more than 185,000 disabled beneficiaries have been taken off the disability benefit rolls because of recovery or return to work.

Rehabilitation services are generally financed jointly by the State and the federal government, with funds from general revenues. In some cases, however, social security pays the cost of rehabilitating people receiving disability benefits. These cases should save social security funds in the long run because the cost of rehabilitat-

ing beneficiaries is less than the cost of paying them benefits.

The social security disability program has helped millions of disabled workers in times of financial stress by providing a regular monthly income when the breadwinner could not work. Thousands of workers have been returned to productive work through the joint efforts of the Social Security Administration and State vocational rehabilitation agencies.

Your social security office will answer any questions you may have about social security's disability program. Call, write, or visit the office. The people there will be glad to help you.

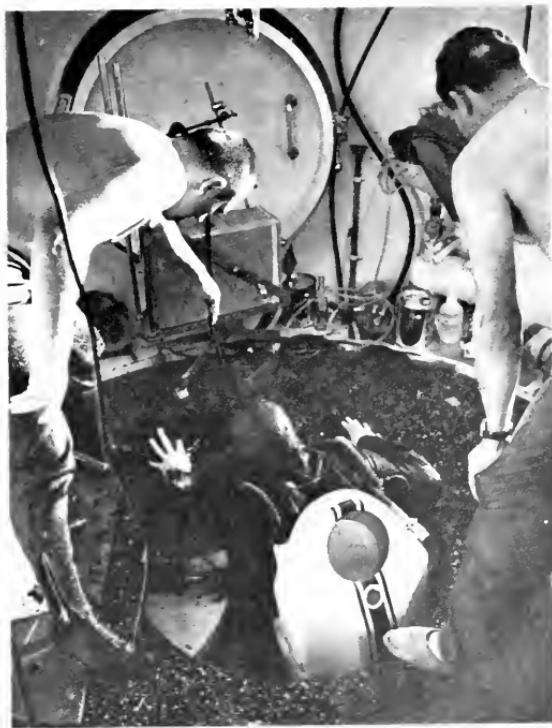
HEART DISEASE STILL EPIDEMIC

The North Carolina State Board of Health, in its recently released report of vital statistics for the year 1968, indicated that there were 23,617 deaths attributable to cardiovascular-renal diseases.

Overall deaths reported in the Tar Heel State for 1968 were 44,396. This points up that out of all deaths in North Carolina for the year 1968, 53.2 per cent were the direct result of cardiovascular-renal diseases.

According to the State Board of Health report, of the 23,617 deaths attributed to heart and kidney diseases, heart disease was responsible for 15,768, stroke accounted for 5,747, atherosclerosis 639, nephritis 257, and other cardiovascular-renal diseases 1,206.

The North Carolina Heart Association notes that while the total number of deaths from heart disease is still holding at about the same percentage of total deaths as in the past five years, the figure of 53.2 per cent is still indicative of the epidemic proportions of heart disease in our State.



NEW EQUIPMENT TESTED—Chief Murray Cato, one of the five divers who participated in Duke University's simulated dive to 1,000 feet beneath the surface of the sea, tests new underwater equipment in the hyperbaric chamber's "wet pot." At left is Chief Sam Smelko, also of the U.S. Navy. Frank Falejczyk of Scott Aviation Corp is on the right.

Duke University Experiment

MAN CAN FUNCTION IN DEEP WATER FOR EXTENDED PERIOD OF TIME

The world that exists one thousand feet beneath the surface of the sea has been opened to human exploration by scientists and technicians on the

landlocked campus of Duke University at Durham, N. C.

In an experiment lasting sixteen days last December, five divers entered the hyperbaric



MONITORING THE DIVE—Duke University Medical Center personnel listen to reports from five divers who spent 16 days in an experimental simulated dive at the Duke hyperbaric chamber. From left are Dr. Herbert Saltzman, director of the hyperbaric unit; Mrs. Laura Sheppard, chief medical technologist; Dr. John V. Salzano, associate professor of physiology-pharmacology; and Dr. Wirt W. Smith, assistant director of the hyperbaric unit.

chamber at the Duke Medical Center and demonstrated that man can function effectively at one thousand-foot depths for extended periods.

The divers, two from the university and three from the U.S. Navy, spent 77½ hours at a simulated pressure of one thousand feet. The rest of the time was spent compressing down to the bottom depth and then returning to normal pressure.

In the experiment the men breathed a mixture of gases

containing 96 per cent helium, 3 per cent nitrogen, and 1 per cent oxygen. The normal concentrations of nitrogen and oxygen in surface air are poisonous or narcotic at the depths to which the men descended.

During their three days at the bottom, the divers underwent a battery of physical and psychological testing. The results, while not yet conclusive, indicate that man can function at such depths with little or no impairment or discomfort.

The exercise tests, which used a calibrated cycle and in which blood gases, expired gases and atmospheric gases were measured, indicated normal function. The psychological tests showed some anxiety on the part of the men, but only what was described as normal under the circumstances.

Some of the divers experienced slight pain in their joints where the joints were fully extended during exercises, but monitors considered this neither significant nor unexpected.

One of the divers experienced a slight case of the bends—a decompression sickness which

occurs when divers ascend too rapidly. But the problem was quickly remedied.

The divers were, from Duke: Delmar L. Shelton, hyperbaric chamber operator and technician, and Frank J. Falejczyk of Scott Aviation Corp., working with the university; from the U.S. Navy Experimental Diving Unit: Lt. Cmdr. James Kelly, M.D., Chief Francis J. Smelko, and Chief Murray Cato.

Dr. Herbert A. Saltzman is director of the hyperbaric unit. Lt. Cmdr. James Summitt is senior medical officer of the Navy's Experimental Diving Unit.

TIP FOR PARENTS OF YOUNG CAMPERS

Sending a child to camp this summer?

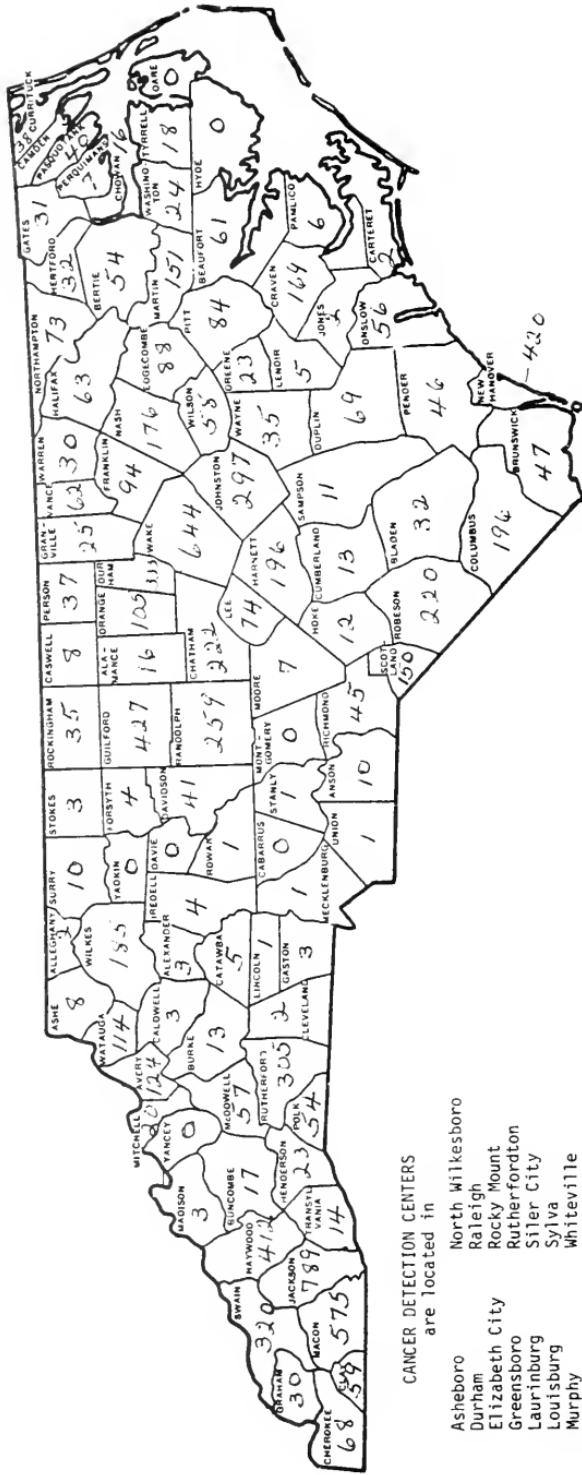
It's always a good idea to check out the camp thoroughly, in advance. Take a close look at the camp site and physical plant, to be sure. But also evaluate carefully the food and water supply and the medical care and staff supervision.

A good camp director will be eager to have you visit, to talk to staff members and campers, and to ask questions.

PERSONS EXAMINED IN CANCER DETECTION CENTERS BY PLACE OF RESIDENCE:

NORTH CAROLINA, 1968

(Total Persons Examined - 8,794)



CANCER DETECTION CENTERS
are located in

Asheboro	North Wilkesboro
Durham	Raleigh
Greensboro	Rocky Mount
Laurinburg	Rutherfordton
Louisburg	Siler City
Murphy	Sylvia
New Bern	Whiteville
North Carolina	Wilmington
Winston-Salem	Winston-Salem

Nonresidents = 60

VITAL STATISTICS IN NORTH CAROLINA

BY GLENN FLINCHUM

In the minds of many people, the word *statistics* connotes an array of dull, dry figures which are of little interest to anyone but a statistician.

If preceded by the word "vital," however, we get a new meaning which becomes quite personal when we consider that all of us at one time or another counted in the statistics of life and death.

The term "vital statistics" as used here applies to records of birth, death, marriage and divorce, as well as information derived from these records.

North Carolina began recording births and deaths on a state-wide basis on October 1, 1913. The motivating force behind the action was the pressing need for birth and death information upon which to base public health programs.

Dr. W. S. Rankin, State health officer at the time, gave this need number one priority in his legislative program. He stated his case as follows:

"... We have reached the stage in public health work in this state from which we can make practically no advance until a vital statistics law is passed."

He further stated that trying to administer public health without vital statistics was like fighting an unknown enemy in ambush: You fire a few shots here and there, never knowing if you're shooting at the right places.

Following the enactment of the law by the General Assembly, the Bureau of Vital Statistics was established and work was begun on the appointment of over 1,400 local registrars in each town and township throughout the State. These registrars collected the certificates for all births and deaths occurring in their districts, made copies for local use, and forwarded the originals to the State Board of Health each month for permanent filing. They also issued permits for burial and transportation of dead bodies. They received a fee for their services of 50¢ per certificate, paid by the county.

Helpful Information

Within a short time, the vital statistics began to produce some basic information which was of tremendous help to the physicians and public health workers who were trying to make the

(continued on page 12)

best possible use of their meager resources. Though far from being precise measurements, the available statistics made it possible to get some answers to such questions as: What sections of the state have the highest death rates? What diseases are the greatest contributors to the death rate? What segments of the population are hardest hit by certain diseases? Within a few years it was also possible to determine the effectiveness of some of the public health measures that were put into effect.

Today, the vital statistics registration procedures are essentially the same as in 1913, except that in most counties the local health departments have taken over the responsibilities of local registrars. This change had several advantages. It was more economical and efficient to use the existing facilities of the local health departments as the central location for registering births and deaths. Also, the local health director could consult with the physicians, midwives, and funeral directors in his county concerning any

medical problems arising in the registration procedure. Another important advantage was the immediate availability to the health director of information concerning deaths from contagious diseases or any other causes which would require his immediate attention.

Individuals Are Responsible

In every county certain individuals are charged with the responsibility for actually preparing and filing vital records. The attending physician or midwife is responsible for completing the certificate of birth or fetal death (stillbirth). If no physician or midwife is in attendance, it is the duty of the father, mother, or owner of the premises to report the birth.

Death certificates are prepared by the funeral director, or the person who takes charge of the body after death. The funeral director must also obtain from the attending physician his opinion as to the cause of death. If there was no physician in attendance, then the medical examiner or coroner must certify to the cause of death.

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Springtime is check-up time for your car. How about you? You can trade in your old car, but your heart has to last you a lifetime. Help make it a long one, says the North Carolina Heart Association, by seeing your doctor regularly.

The central registration of divorces became effective on January 1, 1958. The clerks of court in each county report to the State Board of Health each month all divorces granted in their court during the preceding month. Records are prepared in Raleigh and indexed by the names of both plaintiff and defendant for easy reference. Be-

fore 1958 if the county where the divorce was granted was unknown, it was necessary to inquire of all 100 counties in order to locate the record. In addition to their value to the individuals, these records provide valuable information concerning the extent of the divorce problem in our State,

(continued on page 14)

HOW IT WAS IN THE OLD NORTH STATE

RECREATION NECESSARY FOR HEALTH

The Creator of the universe in His all-wise wisdom implanted in the minds of children the longing for play. Health and growth depend upon the exercise of muscles. The instinct for play, therefore, plays a large part in the development of each individual.

After childhood has passed there is a tendency on the part of most of us to suppress, or forget, this instinct for play. We get so busy striving for wealth or fame, or just trying to make a living, that we are apt to think of play as something unobtainable, something that we have not the time for. Therein we make a great mistake . . .

Nearly all the degenerative diseases result from a lack of play. Mentally and physically we need recreation that really recreates, that relaxes tired muscles, that gives wearied nerves a chance to retain exhausted vitality. Exercise in the gymnasium is fine, but frequently it is too methodical, or else we overstrain. The more simple games, and particularly those that can be played out of doors, do the most good. In those we get the ideal combination of exercise of muscles, fresh air and sunshine, the combination which, taken regularly, means prolonged life and better life.

Health is a state of physical and mental and moral equilibrium, a normal functioning of the body, mind and soul. It is the state when work is a pleasure, when the world looks good and beautiful and the battle of life seems worthwhile. Health is the antithesis of disease, degeneration and crime. To maintain it we must obey the laws of nature which demand that there shall be a proper mixture of work and play, of rest and sleep. And of these we need to place particular stress on play.—R.B.W.

—*The Health Bulletin*, Vol. XXXVI, No. 6, June, 1921.

some characteristics of the persons involved, and the number of minor children.

Marriages were added to the vital statistics family in January 1962. The register of deeds in each county is the local official responsible for the initial preparation and issuance of the marriage license. After the marriage takes place, the minister or other officiant certifies to the date and place of the event, obtains the signatures of two witnesses, and files the completed certificate in duplicate with the register of deeds. Each month the register of deeds forwards one copy of each completed certificate to the State Board of Health. Here again, much valuable data is obtained for use in public health, social and welfare programs. These statistics, when combined with other information, make it possible to estimate or project figures on migration, birth rates, housing needs, and changes in marriage trends.

The tremendous value of these vital records to the individual citizen has become quite apparent in recent years. When World War II began, many people left their homes to work in defense plants or other war-related industries. For security purposes they found it necessary to prove certain facts about themselves. The birth certifi-

cate became the primary document used for proving age, place of birth, and citizenship. Today it is required for many purposes: entering school, obtaining driver's license, employment, and passport. The death certificate is an equally important document for settling estates, insurance claims, court cases, and social security benefits.

Millions of Records

The processing, storage, maintenance, and indexing of all vital records accumulated in the past 55 years (approximately 7,000,000) adds up to a fairly complex job. When the State Board of Health was reorganized in 1950, the former Bureau of Vital Statistics was incorporated into what is now called the Public Health Statistics Section. Each month the section receives and processes records on approximately 8,000 births, 3,500 deaths, 4,000 marriages, and 1,000 divorces. In addition, more than 4,500 certified copies are issued monthly. A person born in this State may obtain a copy of his birth record by writing to the State Board of Health and furnishing his name, date of birth, county of birth, and parents' names. The fee for this service is \$1.00 per certificate. Certified copies may also be obtained from the register of

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deeds in the county of birth.

Those persons who were born prior to the enactment of the vital statistics law, or who for any reason did not have a certificate filed at the time of their birth, may file a delayed certificate of birth with the register of deeds in the county in which they were born. It is necessary, however, to furnish at least three written documents which will prove the facts concerning the birth. These documents may be school records, family bible records, insurance policies, and census records.

Another important part of vital statistics work involves the correction and amendment of records. In the early years of vital statistics registration,

many names were misspelled and sometimes important information was omitted. In order to make any changes on the original certificate, it is necessary for the registrant or parent to furnish proof as to the correctness of the requested change. In some instances, such as a change of father's name, a court order is required before a change can be made.

When a child is adopted, or when an illegitimate child is legitimated by subsequent marriage of the parents, a completely new birth certificate is prepared and no access to the old certificate is permitted except by order of a court.

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THE HEALTH BULLETIN
P. O. Box 2091
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Printed by The Graphic Press, Inc., Raleigh, N. C.

Vital Statistics in North Carolina

(continued from page 15)

In addition to the processing and handling of vital records, the Public Health Statistics Section prepares and publishes reports containing a variety of statistical data which is used not only by public health workers, but also by research workers, county and city planners, school officials, students, and many others. The section also collaborates with other agencies, such as the University of North Carolina, the State Medical Society, and the U. S. Public Health Service in carrying out special studies and research projects. The large volume of records involved requires the use of electronic data processing equipment to produce the many detailed tabulations need-

ed monthly, quarterly, and annually.

As the population of North Carolina continues to increase, and as new public health programs are developed, the Public Health Statistics Section staff will be facing new challenges and new opportunities of service. Such activities as comprehensive health planning and regional medical programs generate new demands for statistical data which must be met.

The primary objective of the section, however, will continue to be to serve the citizens of North Carolina efficiently and well and to preserve for posterity the records of life's most intimate events.



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

APRIL 1969



MEDICAL LAB
ASSISTANT

THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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Editor: H. B. Rogers

Vol. 84

April 1969

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ALSO

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Cover: Patricia Haire, a graduate of the medical laboratory assistants program at Holding Technical Institute, Raleigh, is a staff assistant today. Mrs. Haire received her diploma in August 1967.

Margaret Darst Smith, director of public relations for Holding Tech, supplied the photograph of Mrs. Haire, as well as the photographs that illustrate her story.

CAMP EASTER-IN-THE-PINES

North Carolina's Easter Seal Camp

A boy bound to a wheelchair competes with other disabled children in a unique game of baseball in which the rules of the game are scaled down to fit the handicaps of the team members.

Unusual?

Not at Camp Easter-in-the-Pines, North Carolina's Easter Seal camp.

Baseball, dock fishing, swimming, archery, a trip through the woods to discover wild flowers: rare treats, all, for the handicapped person — but all

possible at Camp Easter-in-the-Pines.

North Carolina's Easter Seal camp, located at Southern Pines, is open to all physically handicapped persons from 7 to 50 years of age who would benefit from a camping experience. The handicaps represented at the camp include those that have resulted from cerebral palsy, polio, visual and hearing defects, muscular dystrophy, spina bifida, accidents, burns, amputations, rheumatic heart, and congenital defects.

Camp Easter-in-the-Pines

1969 Calendar

June 8 - June 14	Staff Orientation
June 15 - June 26	Children, Ages 7-12
June 29 - July 10	Adults, Ages 17-50
July 13 - July 24	Children, Ages 7-12
July 27 - August 7	Teenagers, Ages 13-17



Young disabled campers get expert supervision from well-trained staff at Camp Easter-in-the-Pines.

At Camp Easter-in-the-Pines everyone is on equal footing with everyone else, for all campers are physically disabled. Every cabin has ramps approaching it. Every building has wide doors. Wheelchair paths wind throughout the camp, from the arts and crafts building to the huge main lodge.

The main emphasis at Camp Easter-in-the-Pines is recreation, and a well-trained staff of instructors provides responsible leadership. In addition, a physical therapist works with children in the lake every day.

Camp Easter-in-the-Pines will offer four sessions in the sum-

mer of 1969 to children and teenagers and adults. All physically handicapped persons may be considered for admission.

The cost of a two-week camp session is \$90. Local Easter Seal societies, individual donors and civic groups have helped provide "camperships" for children and adults.

For application forms write:

Camp Easter-in-the-Pines

Drawer 1099

Southern Pines, N. C. 28387

Camp Easter-in-the-Pines is a facility of the Easter Seal Society for Crippled Children and Adults of North Carolina, Inc.

Food Can Be Dangerous

. . . Sometimes

Of the 100 outbreaks of human salmonella infections attributable to specific sources investigated by the National Communicable Disease Center during the three-year period 1963-1965, 61 were traced to foods, 21 to human carriers, and 18 to animal contacts.

There were 51 other outbreaks which were investigated but which could not be traced to specific sources.

Foodborne salmonellosis can

most frequently be traced to eggs or egg products, poultry, or beef and pork products. A host of other foodstuffs have also been incriminated, however, including such items as soya milk, dried yeast, coconut, cotton seed protein, cereal powder, and even a food coloring substance (carmine dye).

Animal feeds have been widely incriminated as potential sources of infection for domestic animals. □

Regional Rural Health Conference

Child health and home health care are topics for the 1969 Regional Rural Health Conference sponsored by the Medical Society of the State of North Carolina.

The conference will be held Thursday, June 12 at Lambuth Inn at Lake Junaluska, starting at 10:30 a.m. It will be open to medical people, laymen and interested citizens who wish to attend.

Dr. Hugh A. Matthews, director of health affairs at Western Carolina University, will preside. Several speakers will participate.

A special feature will be recognition of the 1968 4-H health king and queen and their families.

The Need For Family Planning In North Carolina

By C. HORACE HAMILTON

Associate Director

Carolina Population Center

and

*Visiting Professor of Sociology and Biostatistics
The University of North Carolina at Chapel Hill*

Many counties, cities, and communities have some more or less systematically organized family planning programs. Moreover, the current downward trend in the birth rate is evidence that family planning is practiced by a large percentage of North Carolina families. The practice of birth control has no doubt been facilitated by the development of the "pill" and other contraceptive methods. Because of these trends and facts, many people are under the impression that we need no longer be seriously concerned about the problem of overpopu-

lation or of the need for investing public funds in family planning programs.

If there is any complacency over the need for family planning, a look at the latest available facts about births in North Carolina should dispel any idea that we can now relax and forget about the problem. During the calendar year 1966, according to the Statistics Section of the State Board of Health, there were 92,727 births and 42,218 deaths. The difference between births and deaths, i.e., natural increase, was 50,509. Thus, from one point of view, in 1966, the state had 50,509 more births than were needed to maintain the population at a stable level.

Reprinted from the *University of North Carolina News Letter*, Vol. LIII, No. 3, September 1968.

A similar excess of births over deaths has existed throughout our state's history. As a result of the relatively high rate of natural increase, North Carolina has experienced a heavy out-migration and, at the same time, has increased in population. Most people, intuitively, think that population growth is a good thing, but that heavy out-migration is a bad thing. Just how bad and how good these trends are is a matter of opinion, but it is not the purpose of this paper to discuss population policy. It suffices to point out that rapid population growth, not only in other countries but also in our own state and nation, is creating serious social and economic problems.

There are many ways to measure the need for family planning, although there may be some disagreement as to how many children a family should have. In a free and democratic society the decision on family size is considered to be the prerogative of individual families. Yet many surveys show that most married couples do not want more than two to four children. (In order to maintain a stable population, only about 230 children per hundred married couples are needed to maintain the population.)

In spite of the fact that most women in this country no lon-

ger want the very large families which were common in the rural areas of our nation for many generations, the current birth statistics show that a substantial percentage of North Carolina families are still giving birth to more children than they can provide for even at a modest standard of living. In 1966, the vital statistics show that more than a fourth of the babies were born to North Carolina mothers who already had three children. However, a more refined and accurate estimate of the number of "excess" births may be arrived at by taking into consideration the age of the mother.

On the basis of known relationships between maternal and child health and the timing and number of births, we shall define as "excess" births all those born to mothers either under 15 years or over forty years of age. For all other age groups, we shall define as excessive all births occurring during 1966 to mothers in the following age and birth order groups:

Age of Mother	Excluded Births
15 - 19	Above the 1st order
20 - 24	Above the 2nd order
25 - 29	Above the 3rd order
30 - 34	Above the 4th order
35 - 39	Above the 5th order

Although these assumptions are made partly for the purpose of establishing some sort of reasonable and convenient statistical criterion, it can also be argued that such limits are in the interest of both the individual family and of society which must pay part of the cost of excessively large families among the low income groups.

Actually our definition of excess births is more on the liberal than the conservative side.

tive number of women with zero, one or only two children should increase, there would need to be some increase in the number of mothers with three or more children.

On the basis of the above assumption, it is found that 33,033, or 35.6 percent of the 1966 births were excessive, and most of them were probably unwanted by the parents. This number of excessive births may be broken down by age of mother

TABLE 1
Number and Percentage of Excess Births By Color and Age of Mother,
North Carolina, 1966

Age of Mother	Number and Percentage of Excess Births					
	Total Number	Total Percent	White Number	White Percent	Nonwhite Number	Nonwhite Percent
All ages	33,043	35.6	17,284	27.0	15,759	55.1
Under 15	401	100.0	91	100.0	310	100.0
15 - 19	6,342	29.4	3,033	23.3	3,309	38.7
20 - 24	10,458	31.3	5,763	23.7	4,695	51.2
25 - 29	7,526	38.2	4,290	29.1	3,236	65.1
30 - 34	4,280	40.6	2,162	28.8	2,118	70.0
35 - 39	2,365	43.9	956	27.7	1,408	73.0
40 - Up	2,198	100.0	989	100.0	682	100.0

There are both medical and economic reasons why a mother over 35 years of age should not have any children of the sixth order and above. However, statistically, it is justified on the grounds that a very small number of families with more than five children should be included so that the average number of children per mother will be high enough to maintain the population. If, for example, the rela-

as shown in Table 1.

It is interesting to note that of the 17,201 excess births to mothers under 25 years of age, more than one-half were white (8,887, or 51.7 percent). On a percentage basis, the number of excess nonwhite births is approximately twice that of the white percentage. It should be noted that other studies show excess fertility is associated with low income, educational

attainment, and occupational level, irrespective of race.

The county differences (see Table 2) in the number and percentage of excess births, indicative of the need for family planning, also reflect differences in the social, economic, and educational characteristics of the population. Counties with high percentages of farm people have high percentages of excess births; and the large metropolitan and urban counties have relatively low percentages of excess births.

Greene County, an eastern North Carolina agricultural

county, has the highest percentage of excess births. Practically all of the other counties ranking high in excess births are also found in eastern North Carolina.

Among white mothers the highest percentages of excess births are found in the rural mountain counties, such as Madison, Clay, Alleghany, Graham, and Ashe.

Among nonwhite mothers, the highest percentage of excess births are found in such predominantly agricultural counties as Greene, Halifax, Edgecombe, Jones, and Nor-

Struvite Crystals and Canned Seafood

Glass in your canned shrimp? Probably not.

From time to time people in the canned seafood industry and at the Food and Drug Administration get complaints from consumers who believe they've found glass in their canned seafood—especially shrimp.

Examination, however, usually reveals it isn't glass at all, but "struvite" — crystalline magnesium ammonium phosphate to the chemist — which occasionally forms in canned seafood from normally present constituents.

While struvite isn't actually desirable, it doesn't affect the safety of the food at all, according to FDA. Seafood canners have devoted considerable attention to the problem of struvite formation, but they still haven't been able to prevent it.

If you do happen to find a hard, clear crystalline bit of material in canned seafood, here's a simple test to distinguish between struvite and glass. Simply place the material in warm vinegar for a while. The struvite crystals will dissolve; glass of course, will not.

TABLE 2
Estimates of the Number and Percentage of Excess Births
In North Carolina Counties, 1966

State and Counties	Total Births	Excess Births		Rank of County
		Number	Percent	
North Carolina	92,727	33,043	35.6	
1. Alamance	1,777	496	27.9	94
2. Alexander	329	100	30.4	84
3. Alleghany	136	49	36.0	53
4. Anson	481	220	45.7	13
5. Ashe	354	131	37.0	48
6. Avery	224	71	31.7	76
7. Beaufort	646	242	37.5	46
8. Bertie	415	212	51.1	4
9. Bladen	529	229	43.3	21
10. Brunswick	423	170	40.2	33
11. Buncombe	2,509	785	31.3	78
12. Burke	1,065	303	28.5	92
13. Cabarrus	1,293	413	31.9	74
14. Caldwell	1,272	432	34.0	61
15. Camden	76	35	46.1	10
16. Carteret	544	180	33.1	64
17. Caswell	297	132	44.4	20
18. Catawba	1,653	546	33.0	67
19. Chatham	463	160	34.6	58
20. Cherokee	281	86	30.6	82
21. Chowan	181	60	33.1	65
22. Clay	64	24	37.5	47
23. Cleveland	1,454	563	38.7	40
24. Columbus	947	425	44.9	17
25. Craven	1,346	485	36.0	54
26. Cumberland	4,237	1,493	35.2	56
27. Currituck	121	46	38.0	44
28. Dare	116	34	29.3	89
29. Davidson	1,771	627	35.4	55
30. Davie	311	101	32.5	72
31. Duplin	713	293	41.1	29
32. Durham	2,102	647	30.8	81
33. Edgecombe	1,075	507	47.2	9
34. Forsyth	3,605	1,198	33.2	63
35. Franklin	479	198	41.3	28
36. Gaston	2,987	1,078	36.1	51
37. Gates	151	65	43.0	43
38. Graham	122	44	36.1	52
39. Granville	580	267	46.0	11
40. Greene	281	154	54.8	1
41. Guilford	5,137	1,774	34.5	59
42. Halifax	1,193	592	49.6	6
43. Harnett	928	379	40.8	32
44. Haywood	774	242	31.3	79
45. Henderson	706	236	33.4	62
46. Hertford	412	195	47.3	8
47. Hoke	326	147	45.1	16

48.	Hyde	86	39	45.3	15
49.	Iredell	1,319	497	37.7	45
50.	Jackson	301	90	29.9	85
51.	Johnston	1,005	383	38.1	42
52.	Jones	171	88	51.5	2
53.	Lee	605	196	32.4	73
54.	Lenoir	1,049	400	38.1	43
55.	Lincoln	581	185	31.8	75
56.	McDowell	541	189	34.9	57
57.	Macon	209	57	27.3	95
58.	Madison	251	99	39.4	36
59.	Martin	486	204	42.0	24
60.	Mecklenburg	6,100	1,823	29.9	86
61.	Mitchell	213	63	29.6	87
62.	Montgomery	352	129	36.6	49
63.	Moore	737	288	39.1	38
64.	Nash	1,047	434	41.5	27
65.	New Hanover	1,312	434	33.1	66
66.	Northampton	467	239	51.2	3
67.	Onslow	2,322	680	29.3	90
68.	Orange	905	234	25.9	97
69.	Pamlico	122	40	32.8	69
70.	Pasquotank	471	180	38.2	41
71.	Pender	305	139	45.6	14
72.	Perquimans	136	61	44.9	18
73.	Person	487	196	40.2	34
74.	Pitt	1,352	533	39.4	37
75.	Polk	189	59	31.2	80
76.	Randolph	1,337	357	26.7	96
77.	Richmond	828	357	43.1	22
78.	Robeson	1,997	966	48.4	7
79.	Rockingham	1,416	582	41.1	30
80.	Rowan	1,406	458	32.6	71
81.	Rutherford	849	293	34.5	60
82.	Sampson	842	352	41.8	26
83.	Scotland	566	238	42.0	25
84.	Stanly	721	181	25.1	99
85.	Stokes	444	145	32.7	70
86.	Surry	956	303	31.7	77
87.	Swain	195	78	40.0	35
88.	Transylvania	349	99	28.4	93
89.	Tyrrell	39	7	17.9	100
90.	Union	1,032	403	39.1	39
91.	Vance	663	305	46.0	12
92.	Wake	3,770	1,148	30.5	83
93.	Warren	287	143	49.8	5
94.	Washington	311	139	44.7	19
95.	Watauga	306	90	29.4	88
96.	Wayne	1,668	611	36.6	50
97.	Wilkes	904	298	33.0	68
98.	Wilson	1,202	493	41.0	31
99.	Yadkin	409	105	25.7	98
100.	Yancey	223	64	28.7	91

thampton.

Urban metropolitan counties, such as Wake and Mecklenburg, in general have low percentages of excess births, but even in these counties the percentage of excess nonwhite births is greater than the white. In Wake County only 18.8 percent of the white births are classed as excess. Other counties having a low percentage of excess white births are Orange, Tyrrell, Lenoir, Durham, Mecklenburg, Hertford, Chowan, Gates, and Pasquotank. Among nonwhite mothers having lower than average percent excess births are those of Durham, Chatham, Lee, Guilford, Pamlico, Orange, Randolph, Stanly, Onslow, and Chowan counties.

The data presented in this issue of the News Letter are of great significance from the point of view of developing an effective family planning program. Since nearly all babies are now delivered by physicians in hospitals, the counseling of mothers needing family planning and clinical services can most effectively be carried out by physicians and other professional health personnel at the time a mother is having either an unwanted or a higher order birth. Unfortunately, very few hospitals and physicians (except at the three medical schools in North Carolina) have developed

effective programs for guiding mothers in modern family planning practices.

Since these data apply only to women at child birth, we must not overlook the fact that many women who do not give birth to a child during any particular year may also be in need of family planning. However, by combining data on births by age of mother and birth order for several years, a more complete picture of the overall need for family planning in a county can be derived.

A complete program of family planning in any county involves also a consideration of the social, educational and economic status of the county's population. Many counties now have local family planning committees; and they work closely with the health and welfare departments. However, a survey of family planning programs in the counties shows that health and welfare departments simply do not have an adequate supply of health personnel to do the kind of job required.

More effective family planning, in both public and private programs, will help to: (1) raise the level of living; (2) improve the health of both mothers and children; and (3) improve the overall quality of life—the human dividend — for all North Carolinians. □

MEDICAL LAB ASSISTANTS

*Classroom Study
Clinical Training*



Peggy Fish (left) of Raleigh and Marie Straley of Mt. Pleasant, Michigan, peer into the dual teaching microscope at Holding Tech. Miss Straley's father, a medical technician, sent his daughter to Holding Tech for the medical laboratory assistants course because he knows of the outstanding reputation the school enjoys.

By MARGARET DARST SMITH

The second largest medical laboratory assistants program in the United States is offered in North Carolina by Holding Technical Institute at Raleigh.

The author is director of public relations for Holding Tech.

Holding Tech, a local and state tax-supported member of the North Carolina Community College System, began its medical laboratory assistant program in 1964 with a total of 19 students.

Last fall the enrollment



Etheleen Hartsfield of Bunn, N.C. uses the spectrophotometer to measure homoglobin.

HOW IT WAS IN THE OLD NORTH STATE

GARDEN PRODUCES THREE CROPS

"Plant a Garden" has become a new health slogan. A garden has so many health possibilities that no home should be without one. Among the health products of a garden may be mentioned sunshine, fresh air, and exercise as the first crop. The second crop is the supply of those early vegetables that are so essential to health, in spring and summer—spinach, mustard, lettuce, tomatoes, radishes, peas, beans, squash, onions, etc. The third is a reduced market bill which leaves a neat little sum on which to take a two weeks' vacation in summer.

The Health Bulletin,
June, 1915, Vol. XXX, No. 3.

totalled 50 men and women. These 50 started the one-year diploma program in September. Another group began in March of 1969.

This is the only diploma or degree course offered by Holding Tech in which there are two new classes starting each year. It is made possible by the fact that students spend six months of the course in the classrooms at Wake Memorial Hospital and the final six months of the course in clinical training at various hospitals throughout eastern North Carolina. During the final six month period, students are rotated through the different departments of the hospital in order to develop skills in all laboratory functions. As currently enrolled students leave the classroom, another group may begin the classroom phase of the training.

The curriculum for the medical laboratory assistants course was designed jointly by medical technologists, pathologists, and educators for the purpose of giving the students the necessary knowledge and laboratory practice during the first six months of instruction to enable them to move into a hospital laboratory with a minimum of orientation. Each of the laboratory courses provides experiences similar to those the student can expect to

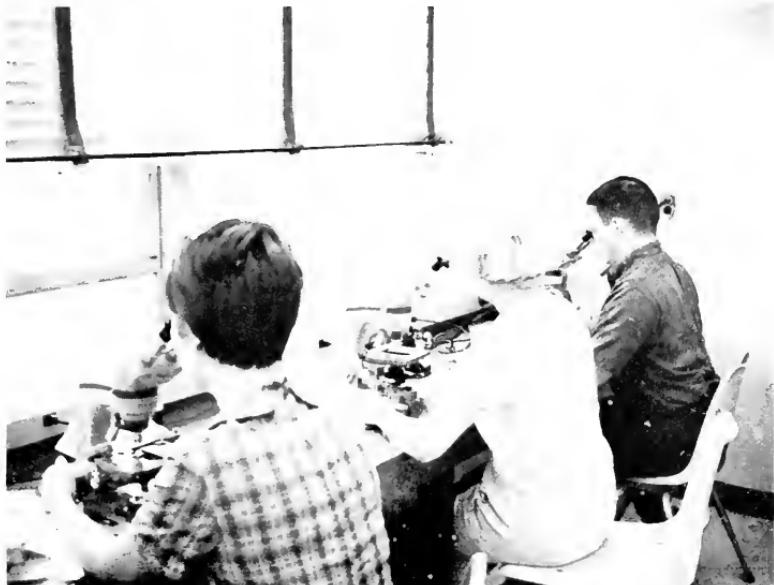
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Two teenagers and a housewife study together in the medical laboratory assistants course at Holding Tech. They are (left to right) Pat Johnson of Raleigh, Anna Whitener of Raleigh (formerly of Haverton, Pa.) and John Davison of Garner, N. C.

THE HEALTH BULLETIN
P. O. Box 2091
Raleigh, N. C. 27602

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Printed by The Graphic Press, Inc., Raleigh, N. C.

Medical Lab Assistants Program (*Continued from page 14*)

meet when they move into their clinical training.

The medical laboratory assistant works under the direct supervision of a medical technologist or a medical doctor. The assistant is taught to collect specimens, prepare slides, and perform routine laboratory tests. Although most of the graduates will be employed in a hospital, many will be hired by doctors to work in their offices, or by agencies conducting medical or industrial research.

Only persons with a high sense of responsibility and the ability to do careful, scientific work should consider entering

the field. Graduates of the curriculum are eligible to take the national examination of the Board of Certified Laboratory Assistants. Upon successfully completing this examination they are awarded the title of Certified Laboratory Assistant.

Holding Tech's students in the medical laboratory assistant program are assigned during the six month clinical phase of the course to leading hospitals and to the Duke University chemistry department laboratory, county health departments, the State Laboratory of Hygiene, and doctors' offices and clinics. □



THE HEALTH BULLETIN

The Official Publication of the North Carolina Department of Health

Helicopter Moves Burn Victim

A burn victim is gently placed in the Chicago Fire Department's Bell 47J helicopter for transfer to a special burn center for treatment. Department Pilot Robert Hack has participated in a number of rescues involving the agency's three helicopters. The ships are used to assist victims of traffic accidents, fly aerial patrol on Lake Michigan, serve as a command post for large fires and work as an emergency supply/medical vehicle. (See article on page 7)



THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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Cover: Helicopters are becoming a necessary means of transportation for the sick, the accident victims and the life-saving needs of the military in Vietnam and elsewhere. Photos and story courtesy Bell Helicopter, Fort Worth, Texas, one of the largest suppliers of helicopters for the United States in Vietnam. (Article on page 7)

Freedom From Want

Food as a Health Need

By Elizabeth W. Jukes

Chief, Nutrition Section
N. C. State Board of Health

Are you old enough to remember World War II and the Four Freedoms? It was said that there were four freedoms worth fighting for: Freedom of Speech and Religion; Freedom from Want and Fear. Most of us would agree that these freedoms are still worth working for. Now we call it Freedom from Want, Freedom from Hunger, and, perhaps, over simplify the situation.

But our understanding of the importance of food to health has grown and deepened considerably in the twenty-five years since those four freedoms were pronounced. We are learning about relationships between growth patterns of children and the protein in the food they eat; about the importance of adequate food to the maximal mental development of very young children; about the importance of having combinations of food values in the intestinal tract at the same time in order that the body can use its food supply efficiently; about the importance of a regular food supply to the child's development of trust in other people. Trust is, after all, one basis on which every society depends.

As important as food is, food alone cannot bring freedom from want. In this day, when so many have so much, it is hard for us to believe that families living in the same county do not have what we consider the essentials of life: a secure house, sufficient clothing for decency and protection, an adequate food supply, clean water, electricity, a cook stove. Somehow we do accept the idea that some people do not have any toilet facility, as necessary as this is to health.

In our country, where food supplies are still more than adequate to feed all of our population, there are some programs that intend to provide the food

needed. These include the distribution of commodity foods (sometimes called surplus foods), the food stamp program, emergency food and medical program, emergency food order, and supplementary food program.

Counties have an option of choosing to administer either the commodity food program or the food stamp program. The commodity foods are available to people certified by the county Department of Welfare to be eligible at a warehouse, usually at the county seat. The food stamp program is a plan for increasing the food buying power of eligible families. Again, the county Department of Welfare certifies families on the basis of income and size of family. A family may pay \$24.00 and receive \$36.00 worth of stamps. These may be spent for foods in grocery stores that agree to accept the stamps instead of cash.

The Emergency Food and Medical Program is available in certain counties as part of their Office of Economic Opportunity Program. The Emergency Food Order is part of the budget of county welfare departments. It provides immediate availability of food for people with immediate needs.

The Supplementary Food Program is a new idea. From time to time, public health workers have expressed concern that although drugs and services are available for low

income patients, food was not available to all patients who had need for it. As a means of meeting this need, arrangements have been made jointly by the U. S. Department of Agriculture, the Children's Bureau of the Department of Health, Education, and Welfare, and the Office of Economic Opportunity for foods to be made available to certain high risk groups in our population.

For the first time, it is the responsibility of health departments and physicians providing free or reduced cost services to patients to prescribe foods. The physician or the professional worker who acts for the physician certifies that the patient would benefit from the foods prescribed. Provided that the patient is already receiving medical services free or at reduced cost, there is no other limitation on who can receive the food.

High risk is a term used to designate people who are in greater than average risk of accident, disease, or death. For the purposes of this program, these people are children from the time of birth to school age and women who are pregnant or who have had an infant within a year. Any of these people who are receiving below cost medical care may have foods prescribed for them.

Since good food is necessary for everyone, especially the people in this vulnerable or

high risk group, who should receive this additional food? Let us take just one example. Anemia is so common among infants that iron is added to some commercial formulas and cereals intended for infants, and some physicians routinely prescribe iron for infants. Much of this need for iron could be prevented if the mothers' diets had been adequate before they became pregnant, or remained adequate during their pregnancies. In that case, the baby would have stored enough iron in his body to protect him until he was old enough to eat foods like cereal, bread, meat, eggs, and green leafy vegetables. These foods would provide his iron needs as they do yours and mine.

Therefore, in prescribing the foods, workers should consider not only the patients' current food intake, but their long-term food habits. Our bodies are strong or weak because of food

habits of our entire life span, not because of the current diet with which we are living temporarily. In other words, every portion of our lives depends upon the condition of all the former portions. Or, to put it another way, the children of mothers who were sick or poorly fed during pregnancy could benefit from supplementary food. This does not necessarily mean a diagnosis of malnutrition, but rather the recognition that the patient would benefit from additional foods.

Foods may be ordered by kind and amount, according to five age groupings. Infants from birth through the third month may be given evaporated milk, corn syrup, fruit juice, and fortified farina. Infants from four months through one year are given the same foods, plus scrambled egg mix.

Children 13 months, through two years, are given evaporated milk, fortified farina, fruit

NORTH CAROLINA DEPARTMENT OF AGRICULTURE
FOOD DISTRIBUTION DIVISION
DISTRIBUTION GUIDE FOR SUPPLEMENTAL FOODS—(HEALTH)

ELIGIBLE CLASSIFICATIONS	Evap Milk 14½ oz Cans	Farina 14 oz Pkgs	Syrup 16 oz Cans	Fruit Juice 46 oz Cans	Scrambled Egg Mix 12 oz Cans	Canned Chicken or Equivalent 3½ oz Cans	Vegetable or Fruit 1 oz Cans	Choc. Milk Bever. Mix 2 oz Cans	Peanut Butter 2 oz Cans	Instant Potatoes 1 oz Pkgs.	Dry Milk 4½ oz Pkgs
WOMEN (Pregnant, Nursing, Post Partum)	2	1	—	3 ½	1	1	7	2	1 ½	1	1
INFANTS (0 through 3 months)	30	2	3	1 ½	—	—	—	—	—	—	—
INFANTS (4 through 12 months)	30	2	3	2 ½	1	—	—	—	—	—	—
CHILDREN (13 months through 2 yrs.)	30	2	—	3 ½	2	1	4	—	—	1	1
CHILDREN (3 through 5 years)	10	2	—	3 ½	2	1	4	—	—	1 ½	1

1/ Two Months Supply—Issue Every Other Month

2/ Prune juice should not be issued for infants. One bottle of prune juice may be issued occasionally in place of other juices for children 13 months through 5 years of age. Women (pregnant, nursing, and post-partum) should be issued one bottle of prune juice, if available, plus two cans of other juices.

juice, scrambled egg mix, canned meat, canned vegetable or fruit, instant potatoes, dried milk. Children three years through five years are given all these foods, plus peanut butter.

Pregnant women, nursing and post-partum mothers are given all the foods given to three to five year age group, plus chocolate milk beverage mix.

Since these foods are ordered as a prescription, certain foods can be reduced or deleted from the order. Maximum amounts which can be prescribed for each age group are set by the U. S. Department of Agriculture. Standards for eligibility are relatively simple and do not exclude individuals receiving other forms of financial or food assistance. This program is not intended to provide the only nourishment for "starving families," but is intended to provide supplemental nourishment for those living under physiologic stress, or, in other words, the stress of rapid growth.

This is the first time food is available as a treatment for a health need. People need to be encouraged to accept and eat the food prescribed not as a charity, but as a remedy. When money is available to the families, they should be encouraged to buy and use the same kinds of foods.

Food *does* make a difference. It can contribute to Freedom from Want. □

Gaston County Hospital Budget Approved

Gastonia—A proposed capital outlay of \$544,235 and an operating budget of \$58,359 for the first year 1969-70 have been approved by the Gaston County Hospital board of trustees. The board has also approved architectural drawings for the new hospital.

Dr. McPheeeters, Former Wayne County Director, Dies

GOLDSBORO — Dr. Samuel Brown McPheeeters, 88, former director of the Wayne County Health Department, died in May.

Surviving: his wife, Mrs. Virginia Gibbes McPheeeters, and a sister, Mrs. F. W. Jarnagin of Nashville, Tenn.

Dr. McPheeeters came to Wayne County from Charlotte in 1937 as director of the health department, which he headed for nearly 20 years. Under his direction the department was expanded from four to 26 employes. In the 1940s he was responsible for the erection of the present county health department building.

Following his retirement he was instrumental in the organization of the Wayne County Mental Health Association. He was a graduate of Washington and Lee University. □

Helicopter

Ambulance

Service -

To the Rescue

A 41-year-old man falls asleep while smoking in bed, touching off a fire resulting in 70 per cent burns over his body.

Two teenagers are critically injured in a freeway traffic mishap.

Snow in record proportions blankets a city, halting all surface traffic. A young man, walking through a park, falls on ice, paralyzing his legs.

Each of the cases is critical in nature and demands rapid emergency response. Fortunately, in Chicago where they occurred, fast medical evacuation to a hospital was available. In each instance a Chicago Fire Department Bell helicopter responded to the emergency call.

Public officials around the country are becoming increasingly aware of the advantages available through use of helicopters in medical evacuation work. In addition to Chicago there are air ambulance programs underway in such states as Pennsylvania, North Carolina, California, Michigan and Montana.

One boost for such efforts comes from the medical community which has seen the helicopter used effectively as an ambulance in Vietnam.

Crew of Superior Ambulance Company carries "patient" from its Bell 47J helicopter after landing at University of Michigan Hospital, Ann Arbor during demonstration of the first private helicopter ambulance service in U.S.



The U.S. Army's 92nd Air Medical Service in Vietnam operates more than 100 Bell UH-1D "Hueys". To date these aircraft have evacuated over 182,000 patients from remote battle sites to field hospitals. Of this total, only two per cent reaching the hospital have died. In World War II the mortality rate was 4.5 per cent; in Korea where helicopters were first used this dropped to 2.5 per cent. The even lower rate of Vietnam is a record in military history.

Military officials in Vietnam now boast that no man, anywhere in the country, is more than 30 minutes from medical aid.

American civic and medical officials are questioning why this cannot be the case at home today. It is unfortunately true that auto accident victims daily succumb on crowded freeways or remote highways while surface ambulances struggle to reach the scene and return to a hospital.

Over a 20-month period in 1966-67 an average 137 U.S. servicemen died weekly in Vietnam combat. During that same period 1,020 Americans died weekly on the nation's highways. This does not represent the burn victims, drownings and other emergency situations that call for fast response.

The first helicopter medical "rescue" mission was recorded on Jan. 3, 1944 when an ex-

plosion rocked a Navy destroyer loading ammunition at Sandy Hook, N. J. Cmdr. Frank A. Erickson delivered plasma to the accident site and was credited with saving many lives.

Since then the heliborne medical mission has become a routine, if not sufficiently widespread, practice. For example:

—This year the first private helicopter ambulance service in the United States was founded. Superior Ambulance Service of Wyandotte, Mich., a Detroit suburb, now operates a Bell 47J in addition to its large fleet of surface ambulances. One of the firm's first airborne missions was the transfer of a brain tumor patient from Dayton, Ohio to Ann Arbor, Mich., a 200-mile trip.

—During the 1968 Indianapolis 500-mile Memorial Day Classic and earlier preliminary trials seven persons were air evacuated by Bell's litter-equipped JetRanger from the track to a nearby hospital.

—Nineteen crew members of an off-shore oil rig 25 miles out in the Gulf of Mexico were picked up by helicopters after a spectacular explosion and flown to a New Orleans hospital. Within minutes all were given emergency treatment. No lives were lost.

One roadblock to greater usage of the helicopter in this role has been the lack of heliports across the nation.

The 1967 edition of the Ver-

tical Lift Aircraft Council's Directory of Heliports/Helistops states there are 1,225 approved landing sites in the United States, Canada and Puerto Rico with another 93 proposed.

Hospital heliports have multiplied from only 34 in mid-1965 to 70 today with another 10 planned. However, leading government and medical authorities warn that the number of hospital heliports around the country is inadequate to properly serve the American public.

By 1972, the Department of Transportation's National Safety Bureau estimates, highway accidents will result in 75,000

deaths annually. In fact, more traffic accident victims occupy hospital beds than do cancer and heart ailments combined. Compared to the life-saving rates achieved in Vietnam, it is apparent the American public must begin to place the same emphasis on saving lives and limbs during peace-time as it does on the battlefield.

In some areas action is underway.

The Montana Aeronautics Commission last year inaugurated a program where it offered to construct hospital heliports anywhere in the state if hospital administrators would



The U.S. Army's 92nd Air Medical Service in Vietnam operates more than 100 Bell UH-1D "Hueys". To date these aircraft have evacuated over 182,000 patients from remote battle sites to field hospitals.

provide usable ground or rooftop space. Once the area is allocated the commission designs, develops, constructs and marks the new heliport. In the first five months the program was initiated the commission received 14 hospital responses.

The U.S. military's helicopters also are being utilized in a limited manner. Hospital detachments at Fort Rucker, Ala. and Fort Sam Houston, Texas evacuated more than 70 highway accident victims last year. A Department of Transportation official recently said there is a strong likelihood the military may make some 200 of its helicopters based around the nation available to the public as rescue vehicles.

And the Trinity Hospital of Minot, N. D., has purchased a Bell helicopter to be piloted by a local flying service for handling emergencies within a radius of up to 100 miles of the hospital. The aircraft is the first hospital-owned helicopter ambulance in the nation.

While this is progress there is much work still to be done.

Medical spokesmen point out that the general public is, in almost all instances, unprepared for the emergency situation. There is a need to have more persons trained in first aid. One partial solution recommended has been to place former military corpsmen in helicopters to serve as a medical aide when the aircraft goes on an emer-

gency call.

There is a need for faster communications, particularly in remote sections. The Bell Telephone system has taken one step to correct this with the recent announcement it will have a central nationwide emergency number, 911.

And, as previously mentioned, there is a need for a new awareness by local government officials, city planners and hospital administrators to provide adequate emergency facilities and procedures, one of which is heliports. □

Scientists Win Awards

Dr. Solomon C. Goldberg, Assistant Chief of the Psychopharmacology Research Branch of the National Institute of Mental Health, Chevy Chase, Md., shared with two former NIMH scientists the Lester N. Hofheimer Prize for Research conferred at the recent 125th anniversary meeting of the American Psychiatric Association at Bal Harbour, Florida.

Other recipients of the award were Dr. Jonathan O. Cole, now Superintendent of Boston State Hospital and Professor of Psychiatry at Tufts University, Boston, and Dr. Gerald Klerman, now Director of the Connecticut Mental Health Center and Associate Professor of Psychiatry at Yale University, New Haven. □

The Home Swimming Pool — Happy Hours or Tragic Ones

The ever-increasing number of automobiles on our highways is one of the factors responsible for the growth of the home swimming pool industry. Today there are more than one-half million such home pools not counting the surface plastic and wading pools. Because of the desire to avoid traffic and crowded highways, there more than likely will be a continued upward trend in this industry.

The home swimming pool can be the source of healthful and happy recreation but it can also result in tragedy. A 1965 study has indicated that there were

almost 500 pool deaths in the United States and that most pool deaths occurred in residential pools, such as pools in private homes, apartments or motels. Over half of the victims were youngsters of age four and under. Most of the tragedies resulted from the lack of supervision, inadequate physical protection, the inability to swim and a disregard for safety practices.

A youngster should never be left unattended in or near a swimming pool. The mother, father or an adult should always be present. Children should never be entrusted to other children. In fact, even adults should not swim or work in a pool unless someone else is present. Slips, falls and physical attacks can be fatal.

Every home swimming pool should be adequately fenced with the entire pool area visible from the home. Fencing should be of sufficient height to prevent entry by youngsters and make it difficult for older people to climb over the fencing and become a trespasser. There should be depth markings on the pool deck and sides and protective float lines to warn of changing depths from shallow to deep water.

Items such as plastic boats, balls and floating toys can be fun for the youngsters but must be used with precaution. Swimmers should never be allowed to rely on these objects as support

for deep-water areas. Pushing, shoving, ducking or running on pool decks should be strictly prohibited. Such practices can lead to disabling injuries and even death. Adults as well as youngsters should adhere to these safety measures. Further, adults should never attempt to swim after drinking alcoholic beverages, eating or taking drugs or medication.

Cleanliness is very important to health and safety. Pool decks should be periodically scrubbed to prevent them from becoming slippery. Papers and other refuse which may lead to slips and falls should be placed in trash containers. Glass bottles should never be taken to the pool area.

To prepare for possible emergencies, it is prudent to have a signal or some warning device in the immediate vicinity of the pool to summon help and a ring buoy to toss to a swimmer in trouble. A telephone should be readily accessible and all pool owners and users should be taught the technique of mouth-to-mouth resuscitation. Whether or not a pool is used for night-time swimming, there should be an immediate source of emergency illumination.

A handy wallet card prepared in cooperation with the American National Red Cross and the U. S. Department of Health, Education and Welfare, containing safety tips, is enclosed for your usage.

Treat Electricity as a Friend

In this modern world of today we have a most valuable servant, steady, dependable and most powerful. As a friend it works through lights, appliances and modern kitchens. It lightens daily chores, brings you comfort and convenience and allows you leisure time to relax and enjoy your favorite radio or television programs. This friend and servant is electricity but it has its rules which must be adhered to. It can be an obedient servant. Ignore its rule and it can become violent and a deadly killer.

Severe or even fatal injuries result when electric energy flows through the body. The extent of injury depends on the path and the amount of current flow. The flow can be fatal if its course is through a vital organ. When the flow of electric current does not pass through vital body organs, injuries are likely to be less severe. However, the muscular reaction to a small shock can startle a person to the extent that he may lose his balance and fall. This involuntary motion may cause serious injury.

While deaths due to misuse of electrical current are few in comparison to other causes, an undetermined number of deaths and burn injuries result from

nearly 140,000 fires throughout the nation caused by faulty electrical appliances, wiring and other electrical equipment.

Statistics indicate that we now have available to us over 150 types of electrical appliances and with technological advancements, many more are anticipated. Consequently, it may be well to mention something about the proper installation and maintenance of electrical equipment and appliances from a safety point of view.

1. Before plugging an appliance into an outlet, check the capacity of your home wiring circuit. Never connect more than 1600 watts on a general-purpose circuit unless you know that the capacity of your home circuit can carry more than this capacity.
2. Cords with worn or cracked insulation should be replaced. Never run cords over hot pipes, radiators or other hot objects. Use convenient wall outlets rather than extension cords or light sockets for connecting appliances.
3. Never run a cord under a rug or door or hang the cord over a nail or sharp object.
4. Connect electrical appliances by putting cord or probe-type temperature controls into the appliance before plugging into the electrical outlet and always turn off the appliance whenever plugging in or disconnecting from the electrical outlet. Major appliances should always be grounded.
5. Electrical equipment should not be handled with wet hands or when standing on a wet or damp surface. Avoid touching an appliance and a grounding source such as a pipe, radiator, faucet or sink at the same time. Common house current can be lethal.
6. Always disconnect appliances before oiling or cleaning. Clean and oil the appliances periodically if recommended by the manufacturer as carbon particles and dirt can set up current paths to exterior paths.
7. Do not overload your circuits. A normal household circuit will carry 15 amperes of electricity. If a 15 ampere fuse blows out continuously, you should add another circuit to your home rather than replacing it with a higher ampere fuse.
8. Wall outlets attract small children and they are tempted to insert hair pins or small objects into the outlet. When not in use, the wall outlet should be covered with a plastic cap or a piece of furniture should be placed in front of the outlet to keep it out of sight.

*Robert F. McDonald, Chief
Injury Control Program
Providence, Rhode Island*

Driving Skills of Senior Motorists

The results of a nationwide study into the driving records of senior motorists may well catapult the over-65 driver to a respected place on the highway and make his current reputation as a "hazard" a myth of the past.

A report on the accident involvement of the senior driver, released by the University of Denver College of Law, is so favorable to the senior motorist that Judge Sherman G. Finesilver, head of the study team, believes it "will be pivotal in refuting current popular thinking about older drivers." In the 31 jurisdictions for which data were available, senior drivers (persons age 65 and over) averaged 37 percent fewer accidents

than would exist if their proportion of accidents were in direct ratio to their proportion of the driving population.

Although senior drivers represented 7.4 percent of all drivers in the states surveyed, they were involved in only 4.8 percent of all accidents in these states. They averaged lowest of all age groups in frequency of injury-producing accidents and 40 percent below their proportionate share of the driving population.

Judge Finesilver expressed the opinion that "the senior driver has been made a scapegoat. The senior driver is not only a good risk, but often may be among the safest motorists on the highway."

. . . from *More Life For Your Years*, 5/69

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How It Was In the Old North State

AN INDECENCY

However chivalrous the purpose of the North Carolina Senate in its passage of an amendment to the marriage laws repealing the requirement of an affidavit of physical soundness on the part of the masculine member of the matrimonial partnership before the contract may be entered into, those voting for it have lent themselves to a mighty sorry business.

A few years since this State had a marriage law that, while not perfect, was a testimonial to the intelligent respect which the more thoughtful of our men and women feel for their kind. Publication of the banns, health certificates for both bride and groom, protected them and the race. Of course a few nice youngsters in a hurry eloped to other states, as did some who could not have been certificated at home. Marrying magistrates of Virginia, South Carolina, and perhaps an occasional Tennessee or Georgia squire, picked up a few dollars which border counties would have liked to retain within their bounds; but what of it?

We were making an honest effort to give to marriage that self-respect to which it as an institution is entitled. We were attempting to avert some of the tragedies resulting from the propagation of the species by its sorriest specimens.

But the past two-three Legislatures have jested or worse at the ideals embodied in the best-contrived marriage law of this section of the United States. It was thought indelicate to require a mother of men to be examined by her family physician as to her fitness for motherhood. It was deemed perverse of public interest to require a notice to the public from those who desired to enter into the contract which most concerns the public.

And now it would seem all bridegrooms of whatever age or physical condition, must be considered Bayards, *sans peu, sans reproche*, and fit for mating at the drop of a hat.—*Greensboro News*.

The Health Bulletin,
June 1935, Vol. 50, No. 6

THE HEALTH BULLETIN
P. O. Box 2091
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Printed by The Graphic Press, Inc., Raleigh, N. C.

Safeguards for Children

Patricia R. Hitt, Assistant Secretary for Community Field Services, Department of Health, Education and Welfare has urged enactment of legislation to protect children against electrical, mechanical, and thermal hazards of toys and other items intended for use by children. A bill now pending in Congress, which has been endorsed by the Food and Drug Administration would provide this protection. Action is sought on the basis of findings disclosed by the National Commission on Product Safety, appointed to make recommendations to the President and Congress on ways to reduce the hazards of household products.

Under the existing Hazardous Substances Act, the law does

not protect children against hazards such as sharp or protruding edges, fragmentation, explosion, strangulation, suffocation, asphyxiation, electric shock, electrocution, heated surfaces, or unextinguishable flames.

The urgent necessity for immediate action, the Assistant Secretary said, is clearly illustrated by the casualty figures gathered by the Commission. More than 15,000 children die each year from accidents. This figure is higher than childhood deaths from cancer, communicable diseases, heart diseases, and gastroenteritis combined. More than half of the children who died as a result of accidents in 1966 were preschool children.

. . . from HEW Field Letter



THE HEALTH BULLETIN

Carolina Blue Board, Inc., Inc.



DR. E. R. HARDIN

Who retired July 1, 1969, after 50 years of continuous service
as Health Director of Robeson County Health Department.
(Story on page 3.)

June 1969

THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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Cover: Madge Pittman of the Robeson County Health Department staff sent us this photograph of retiring Health Director, Dr. E. R. Hardin, with this note: "This is our favorite photo of Dr. Hardin—hope you like it too." We do! His story, beginning on page 3, is a profile of North Carolina's health progress in this past half-century.

Dr. Eugene Ramsey Hardin

Retires After Fifty Years As Health Director Of Robeson County

Here is the story of those years as told in Dr. Hardin's Nomination for The Rankin Award of the N. C. Public Health Association.

Dr. Eugene Ramsey Hardin graduated from the University of Georgia Medical College in 1911. His grades secured for him an internship in Lamar General Hospital. At the end of this service he was appointed intern in Nursery and Child's Hospital, New York City, a pediatric and obstetric service. From there he interned in Willard Parker Hospital, the largest contagious disease hospital in New York City. While there, he had the privilege of observing Dr. Bela Schick, who was doing his experimental work in diphtheria.

In 1915 he accepted the position of Health Officer of Sampson County, N. C. After one and a half years, he resigned this

position to begin private practice there. This was interrupted by the war, and in August of 1917, he entered training for the Army Medical Corps and was assigned to duty as a First Lieutenant at Camp Lee, Va.

In October, 1918, he was sent overseas and landed in France. November 10, 1918, just in time to help the French celebrate the Armistice. After the Armistice, it was Army policy not to release medical officers for several months. It was July, 1919, therefore, before he returned to the United States and to North Carolina. He was discharged from the Army August 31, 1919.

Dr. Hardin began work as Health Officer for Robeson County September 1, 1919.

At that time, much pioneer work had been done by Doctors B. W. Page and W. A. McPhaul, the first health officers, but there was still a vast number of public health problems to be solved. The county, one of the largest in the state, had a population of more than fifty thousand people divided among three races, no paved roads, one hundred and fifty schools, one small hospital, no dairies, and a very low per capita milk consumption.

There were 190 midwives practicing. The maternal and infant mortality was very high, as were deaths from infectious and contagious diseases. The water supply of most people in small towns and rural sections

was obtained from open wells and shallow driven wells. Screens were practically unknown in the rural sections, and sanitary sewage disposal was extremely poor. Many schools did not have sanitary privies and obtained their water from one pitcher pump. Typhoid fever, infectious diarrheas, diphtheria, tuberculosis, malaria, pellagra, and hookworm disease were very prevalent, and thousands of people fell victims to these diseases every year. Venereal disease was very prevalent. Smallpox was common. In the beginning, the main attack of the health department was directed against the major public health problems of that time: Typhoid fever, diphtheria, tuberculosis, infantile diarrhea, hookworm disease, and the high maternal and infant death rate.

Better sanitation, water supplies, and sewage disposal facilities were urged.

The health department staff at this time consisted of the health officer and a secretary.

TYPHOID FEVER has shown a steady decline since 1920. From 1920 through 1943 the health department vaccinated 66,030 against typhoid. Clinics were held in stores, private homes, country churches, voting booths, tobacco barns, or anywhere people could assemble. Now, typhoid fever has become a rare disease in Robeson County.

DIPHTHERIA: The health department began an intensive immunization campaign against diphtheria in 1925, shortly after the advent of the long-time diphtheria preventive toxin-anti-toxin. There has been no letup in the fight since that time. In the four year period 1920 through 1923, five hundred and sixty-two cases of diphtheria with nineteen deaths were reported to the health department. In the four-year period beginning 1925 through 1943 the health department vaccinated 27,505 babies and older children against diphtheria. During this time, more than ten thousand were given the Schick test to determine diphtheria susceptibility. The last case of diphtheria was reported in 1959.

SMALLPOX: In the early years smallpox cropped up frequently, occasionally reaching the epidemic stage. Vaccinations over the years have controlled the disease. No smallpox has been reported since 1931.

TUBERCULOSIS clinics were begun in 1920. Clinics were held by a doctor from the State Sanatorium. These clinics were continued every few years until about 1940, when the state mobile X-ray units were secured for several years. Realizing the need, Dr. Hardin was successful in organizing the Robeson County Tuberculosis Association in 1940. A few years ago, Dr. Hardin persuaded the county commissioners and the

T. B. Association to purchase an X-ray machine that makes small and large films. This machine has provided Robeson County with complete coverage at all times. The Robeson County T. B. Association also pays a part-time X-ray technician for the health department.

The course of tuberculosis in Robeson County gives an example of the problems, the work, and the results of public health in the county. Dr. Hardin had not only the problem of the rampant disease itself, but he had also to deal with the ignorance, superstitions, and fears that had been present for generations. Realizing that the only way to change people was through endless education, he wrote hundreds of newspaper articles, spoke at every possible P.T.A., church, or civic gathering, and visited endlessly with the greats, near-greats, and the nobodys-at-all throughout the county.

That this work was not in vain is evidenced by the decrease of deaths and cases. Examination of contacts has been virtually one hundred per cent for years. Thousands of county residents come voluntarily to the health department each year to receive free chest X-rays.

MATERNAL AND INFANT CARE: Robeson County has one of the outstanding pre-natal clinics in North Carolina. Until recent years, prenatal clinics

were held once each month in each town in the county. Several years ago all of these clinics were consolidated into one clinic held weekly at the health department. Here the patients receive excellent medical care, nursing supervision during the pre-natal and post-natal period, nutrition consultation, and necessary drugs. This has produced healthier mothers and babies, as shown by the lower maternal and infant death rates, and lower premature rate.

When Dr. Hardin came to Robeson County, there were almost two hundred midwives. An article on the history of the health department in the March 7, 1962, issue of the Robesonian described the work done by these midwives. "Midwives came under careful scrutiny. They were investigated and carefully screened. A course for them given in the early 1920's was attended by 130; 100 completed the course. Each was aided in assembling materials to be carried in a little bag. Each was trained in sterilization of materials, the use of antiseptics, the use of drops to be placed in babies' eyes. In those early years, three midwives were taken to court for failing to put drops in the eyes of newborn." The last of these midwives retired in 1962.

The effectiveness of this program was recognized when it played a part in bringing the Merit Award of the N. C. Public

Health Association to Robeson in 1958.

VENEREAL DISEASE has always been a problem in Robeson County. As early as 1920, the fight began and still continues. In 1920 a venereal disease campaign was organized with moving pictures, and a lecturer from the U. S. Public Health Service, here for a five-week tour. The truck moved into all parts of the county, reaching all segments of the population.

The modern developments in the treatment of V.D. have, of course, been of help in the control of this problem. In 1951 there was a county-wide blood testing program, in which clubs, and churches did their part in getting out everyone possible to be tested for possible infection. This blood-testing program was repeated in 1958. Treatments were arranged for those needing them. Through constant checks of persons involved in foodhandling and other related occupations, a check is kept on V.D. and possible contacts are found and treated.

THE CRIPPLED CHILDREN'S CLINIC, which is held the first Friday of each month as regularly as clockwork, began in the 1930's. In this work, Mrs. A. F. McLeod, head of the welfare department, was a strong partner for Dr. Hardin. The 30's were a period of depression and health needs of every type, including those in-

volving handicaps of children, were great. The best doctors in their fields come each month to these clinics to examine new cases and to check on former cases. With the aid of the welfare department and other sources, children who need medical care, surgery or the like are aided. Many a child in Robeson today is a better person physically and emotionally because physical handicaps have been alleviated by the Crippled Children's Clinic.

PELLAGRA today is almost an unknown disease, but when Dr. Hardin came to Robeson it was one of the big problems. Great as it had been, it became even more of a menace in the depression years of the 30's. The county commissioners included enough money in the budget to purchase mineral yeast, a very effective agent to fight pellagra, but a most unpleasant substance to take. Despite the unpleasant taste, when people learned that yeast overcame pellagra, they came in droves for it. It is estimated that in the course of several years, several carloads were distributed, at the request of the people needing it.

HOOKWORM is another poverty disease, but has far more overtones in the health picture since it can be transmitted to others. In the early years the fight began and still continues. There were checks,

(Continued on page 12)

Hodges Heads New State Health Move

Needs In Medical Education To Be Evaluated

By BEBE MOORE
Staff Writer

Former Gov. Luther H. Hodges is chairman of a new committee which will promote health planning in North Carolina.

The North Carolina Committee for Better Health was formed in May, by some 30 persons who gathered at the Statler Hilton Inn here at Hodges's invitation to discuss health needs and the status and coordination of health planning.

The committee's purpose, Hodges said, is "to come up with some ideas as to what we can do to achieve . . . the best health program that North Carolina can afford."

He said such a program includes training of medical personnel, providing adequate facilities, and making available "the best medical care possible at the most reasonable cost to the individual and the state."

May Serve As Nucleus

The committee may serve as the nucleus of a grassroots movement similar to the "good health movement" of the late forties, Hodges said.

This movement was the forerunner of the present active N.C. Health Council.

The earlier movement has been described as the first great statewide thrust for health. It resulted in passage by unanimous vote in the 1949 General Assembly of a package of 12 items that included creation of the four-year medical school at the University of North Carolina and appropriation of state funds to match federal (Hill-Burton) funds for construction of medical facilities.

Several participants in the meeting Tuesday stressed the importance of public involvement in efforts to meet the state's health needs. Dr. Jacob Koomen, state health director and acting director of the Office of Comprehensive Health Planning, said that citizens now "scream to the state legislature (to meet health needs), rather than to the federal government," as they did in the period of the forties.

The committee will seek the best method of developing a comprehensive statewide health plan.

Such a plan was recommended in a statement from Watts Hill Jr., chairman of the State Board of Higher Education.

The statement, read by higher education board director Dr. Cameron West in Hill's absence, said that it is "difficult if not impossible" for the board to plan and promote ways of meeting health needs without a comprehensive statewide plan.

Hill also pointed out that a plan could assign to agencies and institutions involved in health care "responsibility for subsections within its area of special competence," and make it possible to weigh the needs in specific areas "against total needs and priorities."

Ed Rankin, vice president and secretary of the North Carolina Citizens Association, was appointed chairman of a steering committee to set directions for the larger committee.

Others on the steering committee are William Snyder, editor of The Greensboro Daily News; Dr. Koomen; state Rep. Hugh Johnson, D-Duplin, who headed a Legislative Research Commission study of the state's doctor shortage; state Sen. Lindsay Warren Jr., D-Wayne; Dr. West of the board of higher education; Dr. James Musser, director of the North Carolina Regional Medical Program; Dr. Amos Johnson of Garland, former president of the American Academy of General Practice; and Asheville attorney Lamar Gudger.

Raleigh News and Observer
May 14, 1969.

Malpractice Insurance Firm Advises Physicians On Birth Control Pill

A Los Angeles firm dealing in malpractice insurance has advised its 18,000 physician-clients to get patients requesting birth control pills to sign statements acknowledging "awareness of the serious risks involved."

The firm, the Nettleship Co., administers professional liability programs for 12,000 doctors in Southern California and for 6000 osteopathic physicians nationwide. It is the second largest company of its kind.

In a "claims prevention letter" dated May 14, Nettleship's president John C. Allen told doctors of "the increasing awareness of potential complications from contraceptive pills" and disclosed that his firm is "already handling lawsuits dealing with some of these complications."

The Government-approved instructions for prescribing the Pill say that it increases from seven to 10 times the risk of serious and fatal blood clotting compared with the rate in non-users.

Environmental Health Protection

Charles C. Johnson, Jr.
Administrator

Consumer Protection and
Environmental Health Service
Public Health Service

*Excerpts from an address prepared
for delivery at the Spring meeting
of the Southern Regional Legislative
Seminar on Current Public
Health Problems, sponsored by the
Southern Conference of the Council
of State Governments.*

We shape our environment, and then our environment shapes us. We have only to look around us to see that we are well on the way—particularly in our urban areas—to creating a world which can have the most serious adverse effects on human health.

We are “engaged in a race between catastrophe and the intelligent use of technology, and it’s not at all clear we are going to win.”

When we begin to look closely at environmental problems—it is already later than we think, even here in the South.

All concern with the environment is essentially a concern for man—for his total health, happiness, and well-being. The environmental problems that plague us today are largely the result of our narrow pursuit of limited objectives — economic efficiency, fast transportation, agricultural abundance, for example — and our tendency to endow these activities with a life and purpose of their own, separate from or even superior to the needs of the human beings they were designed to serve.

In the Southern states we are not moving fast enough against our environmental problems. We are not alone. As a Nation, we are not dealing adequately with these matters.

Let us begin with food. Maintaining uncontaminated food is a continuing — and indeed a growing problem. It is estimated that over two million Americans are stricken with illness each year from microbiological contamination of food — chiefly salmonellosis.

What is more, the use of food additives to impart flavor, color or other qualities has increased 50 percent in the past ten years, and each of us now consumes an average of three pounds of these chemicals yearly. Pesticides leave residues on food crops, and traces of veterinary drugs occur in meat, milk, and eggs — all this in addition to the chemical barrage that reaches us from other parts of the environment.

Pesticide residues on food continue to be a problem. The truth is that most states in the South — and many agricultural states in other parts of the country — are not doing enough to protect their consumers against ingesting toxic residues on food.

As for drugs, lax state laws encourage quackery which presents serious threats to human health and drains the pockets of the very people who can least afford it.

We should move ahead rapidly in the area of food and drug protection.

Air pollution is one of those problems which is relatively new to the South. However, it is by no means a negligible problem here.

At the present time, toxic matter is being released into the air over the United States at a rate of more than 142 million tons a year, or three-quarters of a ton for every American. There is no doubt that polluted air is a major contributor to emphysema, chronic bronchitis, and lung cancer.

It is estimated that air pollution costs each of the 200,000,-000 American citizens \$65 per year. The cost in damage to agricultural crops alone is more than \$500 million every year.

Another type of environmental hazard that should be given priority here where industrialization is proceeding at such a rapid rate is occupational safety and health. We are finding every year new and subtle threats to workers' health, growing out of our new technology.

The truth is that very few states in the Nation have occupational health programs that even approach adequacy.

There is need for stronger legislation, both at the state and federal levels, to protect workers from occupational disease and injury.

Another problem which is growing in seriousness with every year that passes is the quality of drinking water.

All over the country, we are rapidly approaching a crisis stage with regard to drinking water. The time has come when communities are going to have to allocate substantial resources to modernizing their treatment plants and improve their distribution systems or continue to court serious health hazards from contamination.

Another environmental problem is disposal of solid wastes. Every year, we discard more than 190 million tons of garbage, trash, bottles, cans, and other refuse.

There is no question that existing systems for getting rid of trash are largely obsolete and inadequate.

Very few of these so-called "comprehensive" health plans include the environmental factor. At least six of the states in the South have included environmentalists on their Comprehensive Health Planning advisory councils, so that it appears they intend to give consideration to environmental planning.

No health plan can be regarded as comprehensive unless it gives consideration to environmental improvement—a most important step in preventing disease.

Dental Irrigating Device Approved

The American Dental Association announced recently its approval of the Water Pik irrigating device, made by the Aqua Tek Corp. as an "effective aid to the toothbrush as a program of good oral hygiene."

Such a seal of approval is the first the organized dentists have granted to a water jet spray device for cleaning teeth and gums. Previously, the ADA has given its commercially coveted approval to four brands of toothpastes, all containing stannous fluorides.

By the same token, a number of other water jet cleaning devices have also applied for ADA sanctioning.

Apparently such approval will be a requirement for ADA approval of any of the many water jet appliances now on the market. Another criterion, the Council statement said, will be that all such irrigating devices must have safety valves to accommodate increased pressures in water tap lines.

The device's makers were also required to notify users that "the patient should consult his or her dentist regarding possible contraindications of its use and also regarding his advice as to the appropriate degree of pressure to be used."

(Continued from page 6)

tests, treatments, attempts to inform people as to the control of hookworm. Today there are none of the more virulent problems, but hookworm is still being fought. Many Home Demonstration clubs have aided in recent surveys, to find sufferers from this disease which wears down the body and saps the energy.

RABIES was very prevalent in Robeson County, and in many years reached the epidemic stage. Finally there were so many rabid animals and so many people had to take the antirabic vaccine, that the county commissioners were persuaded to employ a full time dog warden. The warden was employed in 1952. In the short period since then, vaccination of dogs, and destruction of stray dogs have brought rabies under control. No rabid animals have been reported since 1957.

PRE-SCHOOL CLINICS over the years have been one of the department's big projects. Thousands of school children received check-ups in the spring, so that physical defects could be found and remedied during the summer. This meant that healthier children entered the first grade, better prepared to meet the challenge of school and to achieve in school, from the very first.

For many years there was a program by which all ninth grade students were included

in a special examination and indoctrination program. This program included education of the children in the work of the health department.

Dr. Hardin, having observed for many years the frequency of burns in children especially among the poorer people, and the terrible suffering, the long, drawn-out hospitalization, and great expense had always felt that there must be some way to prevent many of these accidents. Dr. Hardin and the Accident Prevention Section of the N. C. State Board of Health worked to obtain a Federal grant and a trained health worker from the U.S.P.H. Service to work out a burn prevention program that could feasibly be adopted by any ordinary health department with its existing personnel and facilities. This program is still active and much basic work has been done.

VITAL STATISTICS play a big part in the health picture. It is important that there be accurate records of births and deaths, and causes of death. In 1953 the control of the Vital Statistics was turned over to the health department. All records are kept in the office of the department and there is a feeling that this change has produced more accurate information, and information more readily available at need.

AUTOPSY PROGRAM: Throughout the years many young babies died without med-

ical attention in Robeson. Cause of death would be given by the coroner as "natural causes". In cooperation with the State Board of Health, Dr. Hardin secured a small Federal grant to establish an autopsy program to try to find the cause of such deaths in these infants. About 36 autopsies were done, the cause of death in most of them was found to be pneumonitis or pneumonia.

Opposition to the department in early years was overcome by popular feeling. In 1927, a former sheriff of Robeson County who had been away for several years, returned and was elected to the State Legislature. After his election he introduced a bill to abolish the health department, the home and farm agents offices, and the welfare department. The county agencies were printed on a separate ticket and the people at the polls were to vote "yes" or "no" as to whether agencies would be abolished. Dr. Hardin visited, talked, persuaded. The health department was not only sustained but secured more votes than the top politician running for office: A fine indication of the affection of the people for Dr. Hardin and their belief in his work. Surely the people of Robeson County know by experience the truth of the late Dr. George M. Cooper's words: "The words of Dr. E. R. Hardin should never be doubted, because of the many health

officers in North Carolina, none are abler".

Robeson County could provide a kaleidoscope of health problems, with which Dr. Hardin was in constant contact, but in 1937, he spent four months at Ann Arbor, Michigan, at the University of Michigan Public Health School, learning about what other places were doing in public health. This study made with the approval of local and state authorities received some financial aid from them, and a substitute was found for Robeson for the interval.

Dr. Hardin has served as President of the Robeson County Medical Society and says of his fellow doctors that they have always been most cooperative in public health work. Prior to being president of the society, he was secretary for five years. The presidency of the local medical society was followed by his being President of the N. C. Public Health Association. In both organizations, he is a life member.

His work received official recognition in 1958 when Robeson County Health Department received the N. C. Public Health Association Merit Award, noting in particular: Public relations with various agencies, education and service in maternal and child care, cooperation with teaching institutions.

The department has provided orientation training for many nurses and sanitarians from the

State Board of Health through the years. In 1925 it was made a training center for nurses. Many doctors and nurses in the public health field from Europe, Africa, Asia, Canada, Mexico, and South America have visited the department for observation.

Dr. Hardin's first travels in Robeson, in 1919 were made in a flivver, over dirt roads, that could change to mud. Many people still used the horse and buggy, and to an extent public health work was in the horse and buggy stage. It is easier now to reach every corner of the county; the public health office is more accessible to those who need help. The number needing help has increased as the population of the county has almost doubled.

In 1919 Dr. Hardin was the whole department, assisted by one clerk. Today he heads a staff composed of seven public health nurses, three sanitarians, and three clerks. His office, a single room in the court house, has grown into a whole building near Lumberton devoted to public health. This is a tribute to Robeson County's recognition of health needs and the place the department holds in the development of the county. It's a tribute too, to Dr. Hardin, for it has been his hand which has guided the department for so long as it has grown in the confidence of Robesonians.

Education and service have

meant that more know about public health services and are more willing to use them. Some health problems may have been eradicated, some controlled, but health is still vital and Dr. Hardin is still fighting for better health with the same vigor as in the early years. Time has brought more understanding that changes come slowly, that people don't give up old ideas overnight, that indoctrination is needed, but the fight to make Robeson County a healthier county for all its residents goes on.

Those who know Dr. Hardin have seen true achievement—lasting changes for the better in things that matter: Stronger, healthier children, mothers who can bear their children with confidence, rear them with hope, and send them out with knowledge and ability to build better lives. All this he accomplishes with penetrating interest, but without dramatics; with irresistible persistence, but with a gentle warm consideration for everyone; with seriousness, but with a never failing wit and good humor; with vision, imagination, and practical wisdom.

Dr. Hardin once said, "I have always felt that next to religion, Public Health is the most important service one can give his fellowman". This service Dr. Hardin has given with whole-hearted abundance. He has given himself.

Preventive For Chicken Pox Reported

Development of a preventive injection for chicken pox (*Varicella*) is reported in the current issue of the New England Journal of Medicine.

It doesn't mean much to most children for whom chicken pox is a mild, self-limited infection.

But certain children, highly susceptible to the rash-producing disease, may suffer serious consequences or even die from chicken pox. These are the kids who have lost or perhaps never had an innate ability to throw off even minor infections. For these the authoritative medical journal hailed the achievement as "freedom from risk of this serious viral infection."

The particularly susceptible children are those whose de-

fense mechanisms have been impaired by such diseases as leukemia, or those born with a condition called agammaglobulinemia, a relatively rare state in which blood-forming elements are unable to produce antibodies, blood substances specifically resistant to certain infections.

The newest chicken pox preventive, which reportedly works within three days of exposure to the causative virus, is called passive immunization with ZIG. ZIG is medicalese for Zoster Immune Globulin. It is obtained in potent amounts from the blood of persons recovering from herpes zoster, usually manifested as so-called cold sores. They develop large amounts of antibodies against the same virus that causes cold sores and chicken pox.

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Printed by The Graphic Press, Inc., Raleigh, N. C.

Live German Measles Vaccine Licensed

Secretary of Health, Education, and Welfare Robert H. Finch announced in mid-June approval of the first license in the United States to produce a live attenuated German measles (rubella) virus vaccine.

The license was given to Merck Sharp & Dohme, West Point, Pennsylvania.

Its vaccine uses the HPV-77 rubella virus strain which was developed by National Institutes of Health scientists and grown in a duck embryo cell culture system developed by Merck virologists.

Dr. Hardin's Retirement

Dr. Eugene Ramsey Hardin has rendered a greater length of devoted service to North Carolinians than perhaps any individual in the public health field. But more important than his duration of service as Robeson County Health Director has been the tremendous impact made upon the health and well-being of our citizens during his tenure. The benefits gained over the years through control of communicable diseases, malnutrition and so many other health problems have spread far beyond Robeson County and have enriched the lives of everyone in this state and of those yet to come. Dr. Hardin retires with the admiration of his fellow health workers as well as the appreciation of his fellow citizens.

Jacob Koomen,
State Health Director



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

Summary

Report

of

1969 State Legislation

Affecting Health

JULY 1969

THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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N. C. Health Council To
Meet In December 16

Cover: Important Health Legislation was enacted by the 1969 General Assembly. On page three and following pages are a selected presentation and listing of these Acts. This issue will serve many persons as a ready reference.

Summary Report of 1969 State Legislation

*Concerning The Responsibilities of The North Carolina
State Board of Health and Other Health Related Acts*

The 1969 General Assembly established a record for duration of its session. During this period, many Health and Health-related proposals were made. During the first few days of the session, two important bills were thrown into the hopper. One—the mandatory licensing of Day Care Centers and, Two—revocation of drivers license for 60 days in the event of refusal to submit to chemical tests of breath or blood for alcoholic content. This is known as Implied Consent. Both of these important pieces of legislation languished in the Assembly, amended many times, until adjournment was imminent.

All of the various Day Care Licensing proposals met defeat. The Implied Consent Bill was amended to provide an immediate hearing on the question of revocation, which became law on the day before adjournment, and is regarded as a vital weapon in the promotion of Highway Safety, about which so many are concerned at this time.

Our Vital Statistics Laws, which deal with the registration of birth, death, marriage, and divorce for North Carolina have been revised and brought up to date in accordance with a model law recommended by the U. S. Public Service. Your local Registrars will find that the changes clarify and simplify the provisions and should promote efficient administration.

Many of you, including City and County officials, have been confronted with the rapid growth of the problem of adequate and effective disposal of garbage and waste. A new law was enacted,

identified as the Solid Waste Disposal Act which will enable the State Board of Health to study the varied problems, receive Federal Funds and suggest uniform standards and guidelines to local units to cope with this major responsibility.

In recent years, there has been a dramatic increase of public interest in health matters and the utilization of physicians, other Health personnel, and Health facilities.

We hear much about the shortage of Health Manpower. Considerable legislation was introduced and ratified to help alleviate this condition in the form of provision or encouragement for training of physicians, nurses, medical aides, and the expansion of medical facilities.

Osteopaths who meet specified educational and training background under the North Carolina Medical Examiner Board were authorized by the Assembly to practice Medicine and Surgery. This recognition has been accorded by many other states.

Sponsored by the Governor, the North Carolina Housing Corporation Act was passed, which will assist persons and families of low income to finance residential housing. This progressive legislation authorizes the issuance of up to Two Hundred Million Dollars in Bonds and Five Million Dollars for Research and Development of adequate and sanitary housing for families in need, and is geared to the promotion of the health, safety, welfare and prosperity of North Carolina citizens and the sound growth of communities.

Authority was granted for counties to create ambulance commissions to operate ambulance services if considered feasible; a law to clarify and strengthen the authority of Cities, Counties, and regional structures to deal with the growing menace of Air Pollution, subject to approval of the State Board of Water and Air Resources; a Harmful and Dangerous Drug Study has been authorized by the General Assembly; likewise, the Legislative Research Commission will make a study of licensing of Clinical Laboratories, personnel and the operation of Blood Banks, an Anatomical Gift Act was passed, for the legal donation of parts of the human body such as the heart and kidneys for the benefit of mankind; and, lastly, adequate financial support was provided for the effective implementation of the important State-wide Medical Examiner System enacted by the 1967 General Assembly.

The following bills concerning the work of the State Board of Health were ratified: (Effective date is shown in parenthesis.)

SENATE BILL 479—AN ACT TO AMEND G.S. 130-13 and 130-14, SO AS TO AUTHORIZE THE ADDITION OF MEMBERS TO COUNTY AND DISTRICT BOARDS OF HEALTH. This bill directs the ex-officio members of a County or District Health Board to appoint two additional “public-spirited citizens” to the Board, should the Board(s) of Commissioners request such action. Effective June 5, 1969—Copies of this Act may be secured from the Community Health Division, State Board of Health.

SENATE BILL 642—AN ACT TO PROVIDE FOR THE LICENSING OF NURSING HOME ADMINISTRATORS; TO CREATE THE NORTH CAROLINA STATE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS; TO PRESCRIBE ITS MEMBERSHIP, POWERS, DUTIES AND FUNCTIONS; TO PROVIDE REQUIREMENTS FOR LICENSURE AS A NURSING HOME ADMINISTRATOR; AND TO PROVIDE FOR LICENSE FEES. (Effective July 1, 1969 but no licenses shall be required or issued prior to October 1, 1969.) Copies may be secured from the Nursing Home Section, N. C. State Board of Health, P. O. Box 2091, Raleigh, N. C. 27602)

SENATE BILL 714—AN ACT RELATING TO THE PLANNING, DEVELOPMENT, AND CONDUCT OF SOLID WASTE DISPOSAL PROGRAMS.

Chapter 130 of the General Statutes of North Carolina was amended by adding Article 13B. This act designated the North Carolina Board of Health as the agency responsible for a State-wide solid waste disposal program and for providing stan-

dards for the establishment, location, operation, use, and discontinuance of solid waste disposal sites and facilities. (Effective June 17, 1969.) Copies may be secured from the Sanitary Engineering Division, N. C. State Board of Health, P. O. Box 2091, Raleigh, N. C. 27602)

SENATE BILL 739—(JOINT RESOLUTION) DIRECTING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE QUESTION OF THE LICENSING OF CERTAIN CLINICAL LABORATORIES.

This is a joint resolution directing a Legislative Research Commission to study the feasibility of licensing of clinical laboratories specifically including blood banks and personnel who examine human specimens for diagnostic purposes. The resolution also directed the Commission to include public health laboratories in the State. (Effective July 1, 1969) Copies of this resolution may be secured from the Laboratory Division, N. C. State Board of Health.)

SENATE BILL 766—AN ACT TO ESTABLISH ARRANGEMENTS FOR THE EXAMINATION AND CERTIFICATION OF WATER AND WASTE WATER TREATMENT FACILITY OPERATORS IN NORTH CAROLINA.

Chapter 90-A of the General Statutes was amended by adding a new article to be known as Article 2. This act provides for the examination of water treatment facility operators and certification of their competency. It establishes a Board of Certification within the State Board of Health, provides for the classification of facilities and operators and sets up provisions for the

mandatory certification of operators in charge of water treatment facilities. (Effective July 1, 1969) Copies of this Act may be secured from the Sanitary Engineering Division, State Board of Health, Raleigh, N. C.)

HOUSE BILL 24—AN ACT TO EXTEND THE IMMUNITY FOR REPORTING CANCER TO EMPLOYEES OF PHYSICIANS, PATHOLOGISTS, HOSPITALS, AND OTHER MEDICAL FACILITIES.

This law supports the physician who reports cancer and therefore, should assist in our future results. The number of the law is General Statute 130-184.2. (Effective February 11, 1969) Copies of this Act may be secured from the Personal Health Division, State Board of Health.

HOUSE BILL 1060—AN ACT TO REVISE THE VITAL STATISTICS LAWS OF NORTH CAROLINA. This Act extensively revised the vital statistics laws of North Carolina, giving our state a Model Act for administering vital statistics procedures and requirements. (Effective October 1, 1969.) Copies of this law will be available from the Public Health, upon request.

Other Health Related Bills RATIFIED—1969 General Assembly

<i>Senate Bill</i>	<i>Introducer</i>	<i>Subject</i>
36	MacLean.	Robeson County garbage removal
44	J. White	Uniform fees for registrars
61	Burney	Autopsy statute revision
66	Burney	Per diem conforming changes
184	Burney	Local air pollution control
185	James	Diploma nursing school credit
198	Henley	Med student recruitment

199	Henley	Med. schools-increase grads
200	Henley	Premed education need
211	James	Nursing instructors
225	Johnson	Johnston Co. garbage disposal
264	Patterson	Local Retirement System revision
339	Bailey	Welfare law recodification
341	James	More diploma nursing schools
345	Henley and Bailey	Pharmacy conduct code
365	Boger	Practical nursing credit
369	James	Nurse training, 75-bed hospitals
382	Allsbrook	Sanitary district board pay
392	Saunders	Montgomery County Water system
393	Nielson and Bagnal	Forsyth County Ambulance
407	Nielson and Bagnal	Ambulance service
409	Nielson and Bagnal	Ambulance service liens
419	Warren	Sampson County garbage disposal
468	McGeachy	Amending drug laws
454	James	Nursing school credits
500	Currie	Physical Therapy Practice Act
567	McGeachy (Joint Resolution)	Harmful drugs study
625	James	Nursing Board Credits certification
701	Rauch	Dentists' provisional licensing
702	Patterson	Ambulance services: You must pay
726	Gurganus	License child-care organizations
747	Larkins	Birth certificate adopted child
756	Penn	Mental Health Council titles
757	Penn	License mentally ill facilities
792	MacLean	No coloring in bread
806	Gurganus	Advisory Comm. Medical Assistance
842	James	Recruit health professionals/funds
857	Allsbrook (Joint Resolution)	Governor study health agencies
875	Burney (Joint Resolution)	LRC study water/air resources

* * * * *

<i>House</i>	<i>Introducer</i>	<i>Subject</i>
5	Boger	Implied consent chemical test
19	S. Johnson	Capital Appropriations
20	S. Johnson	Budget Appropriations
60	Jones	Uniform Anatomical Gift Act
64	Paschall	TB sanatorium charges
73	J. Ramsey	Breatherlizer Demonstration
96	Strickland	Adopted Persons' Name Change
237	McMichael	County ambulance Commission
278	Mills	State aid for nursing schools
300	Johnson of Duplin	UNC Med. School maintenance funds
306	Johnston	LRC Health Manpower Study
307	H. Johnson	UNC family medicine professor funds
340	Warlick	Catawba County Ambulance service without pay
346	McMichael	Rockingham County Garbage Disposal
400	Warlick	Pasq. County Ambulance Employee Pay
414	Martin	Employment Security Law Revision
444	Bryan	Cumberland County trash removal & sewer assessment
468	H. Johnson	Licensing Osteopaths
587	Love	Sanitary district water system
611	Love	County Medical examiners amendments
626	Short	Obtaining Chiropractic services
653	H. Johnson	Private med schools State aid
672	Coble	Ambulance charge garnishment
719	Eagles	Edgecombe County Board of Health pay
787	Twiggs	N. C. employees travel/subsistence
817	Falls	Teacher retirement allowance
840	Andrews	Marriage physical examination
853	Paschall	LRC Study Use of ENC Sanatorium
903	Johnson	Small watershed clarifications
906	Ridenour	Guilford County water/sewer assessments
965	Twiggs	Hearing Aid Board

1019	Eagles and others	Low income housing corporation
1169	H. Campbell	Public records subpoena
1192	S. Johnson	Sewer system debt
1199	Reid	ECU med. school study
1274	H. Johnson	Medical license revisions
1286	S. Johnson	Department of Administration veto state/reg'l. plans
1329	Royall	Require eye safety in schools
1392	Carson	(House Resolution) LRC pesticide study
1401	Jernigan	Delinquent ambulance charges
1420	Reid	ECU allied health funds
1422	H. Campbell	Correcting H 1169/public records.

Fifty-eighth Annual NCPHA

Mark September 17, 18, and 19 on your calendar for our 58th Annual North Carolina Public Health Association Meeting. The Buncombe County Health Department is hosting our convention this year. The Convention Planning and Local Arrangements committees have been busy preparing for the biggest meeting of our association yet. We need your presence and invite your participation in all the functions and activities of the convention. Please make a special effort to attend.

The Grove Park Inn is one of the most picturesque convention sites in North Carolina and its setting is especially beautiful in the fall.

**E. A. Pearson, Jr., D.D.S
President**

Dr. Paul Dudley White

and others claim

Stress is Overrated

as a Factor

In Heart Attacks

Stress has been overrated as the cause of heart attacks, according to Dr. Paul Dudley White, well-known cardiologist. "I've seen people at 80 who have lived under stress and are perfectly healthy. If travel, stress, and lack of sleep would give you a heart attack, I should have had one long ago . . . and I'm 83," the Boston cardiologist said in an interview in Atlanta recently.

Dr. White, Dr. Frederick J. Stare, Dr. Thomas R. Dawber, and other prominent cardiology experts were in Atlanta during May to participate in a two-day

symposium devoted to the prevention of heart diseases and stroke. The seminar, sponsored by Grady Hospital, the Georgia Regional Medical Program, the Georgia Department of Public Health, and others, was held at Grady Memorial Hospital.

In talking about the challenges of cardiovascular disease prevention, Dr. White cited examples of teens and other young people who can be identified as candidates for serious heart trouble in early life. Four identifying marks were mentioned by the cardiologist: heredity, family history of diabetes, reg-

ularly high cholesterol level, and family history of heart disease.

Heredity Important

"Heredity is a very important risk factor in early heart attacks," Dr. White said. "When we know that we can identify early those who are likely to have coronary disease, we should prevent early coronaries." Early coronary risks, according to Dr. White, are associated with a certain body build. Candidates for early attacks are normally big, broad, muscular men with big bones. Those with this type of body build, the physician pointed out, are also more likely to gain weight early. To substantiate his comment, Dr. White pointed to a study of 100 young men who had heart attacks before age 40; there was not a single slightly built man in the group, he said.

Those from diabetic families have more early heart disease, as well as those who have a high serum cholesterol level repeatedly confirmed, Dr. White said. He recommends a cholesterol test for everyone before the age of 20.

Family history is also important in detecting those who are at high risk for coronary disease. It is the responsibility of every family to keep complete

medical records—tests, illnesses, immunizations—which will eventually be of great value to an individual's doctor, to his children, and to his descendants, the physician said.

"We're eating too much . . . smoking too much . . . and not getting exercise," the cardiologist continued. "We need to get back to the old YMCA triangle: body, mind, and soul . . . and body comes first on the triangle."

Need to Exercise

In looking at obesity, a factor commonly associated with heart disease, from another point of view, Dr. Stare said that "most obesity is due to physical inactivity rather than over-eating. We like to eat. It tastes good," he said. "Therefore, if we want to enjoy this life, we've got to get into the habit of exercising." The chairman of the Department of Nutrition, Harvard University School of Public Health emphasized the importance of caloric balance; that is, using the calories that we eat.

Dr. Stare pointed to a study of pairs of brothers; one brother in each pair lived in his native Ireland while the other had moved to Boston. The study indicated that those who remained in Ireland had fewer heart attacks although they ate more than those living in Boston. The

reason, according to Dr. Stare, was that those remaining in Ireland exercised more and weighed less than their brothers in the United States.

Regular exercise, so necessary for maintaining the proper caloric balance, can become a part of an individual's everyday routine, Dr. Stare pointed out. "A brisk, 15-minute walk, for the average male, uses 75 calories," the physician said. "Anyone who can arrange for two additional 15-minute walks each day can burn 150 calories to take care of the extra food he eats." Regular exercise, Dr. Stare pointed out, is more important than harder, less regular exercise.

The heart specialist recommended that young people follow three rules to reduce his chances of early death from heart attack:

1. Don't gain weight after age 22.
2. Be physically active all of your life . . . walk up stairs . . . walk to lunch.
3. Don't smoke.

Dr. Frederick J. Stare of Boston agreed with Dr. White that stress is overrated as a cause of heart attacks. "As far as I know, there is no evidence that stress alone is responsible for coronary heart disease," the physician said. "Stress is high-

ly individual," Dr. Stare continued, "and in our society, the hard-driving person is *also* the person who likely smokes too much, is physically inactive, and gains weight." For those under pressure, Dr. Stare quoted his teenage daughter, "Cool it."

Heart Attack Survival

Dr. Thomas R. Dawbar, associate professor of medicine at Boston University Medical Center, noted that exercise does not necessarily prevent heart attacks. "The real evidence is not that those who exercise have fewer heart attacks, but that they have a much greater survival rate. The real benefit of exercise, then, is the ability to survive a heart attack."

To further reduce the incidence of heart attack, Dr. Stare emphasized the need for a change of diet. He noted that "the ultimate solution of this problem, that is a change of diet in the direction of less total calories, less saturated fat and dietary cholesterol, and more polyunsaturated fats, will come from the food industry itself. Tasty, pleasant, attractive, and nutritious foods—our usual foods—can be manufactured with the above principles built into them."

from *Georgia's Health*,
June 1969

COURSES IN NURSING

The School of Nursing at UNC (Chapel Hill) is offering the following courses: "Innovations in Clinic Nursing: Patients, Personnel, Practices" for nurses in health dept. clinics, mental health clinics, out-patient clinics and emergency rooms of North Carolina, October 6-17, 1969, March 2-6, 1970. A project to be completed at home is designed for the interim between the two sessions.

The visiting professor is Apollonia Adams.

"The Scientific Approach to Supervision of Cardiac Units: Personnel, Patients and Practices" November 3-14, 1969. Visiting Faculty: Kathleen G. Andreali, Educational Coordi-

nator, Duke University Medical Center, Durham, North Carolina; Joan Ganong, Nursing Supervision Consultant, W. L. Ganong Co., Pittsburgh, Pa. UNC Faculty: Bonnie K. Hensley, Asst. Prof., Course Coordinator; Audrey Booth, Asst. Prof., Core Staff Nurse, N. C. Regional Medical Program; Nancy Hart, Instructor, Clinical Specialist, cardio-vascular nursing.

Apply to: Dr. Susanna L. Chase, Director, Continuing Education Program, School of Nursing, University of North Carolina, Chapel Hill, North Carolina, 27514.

Traineeships are available for both courses.

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Stroke Deaths Are Declining

Since 1950 the death rate from stroke has been declining. According to the 1968 Vital Statistics Release by the North Carolina State Health Department over 5,000 North Carolinians succumb to stroke or as it is known in medical terms, Cerebrovascular Accident.

What is a stroke? A stroke occurs when the blood supply to a part of the brain is reduced or cut off and as a result the nerve cells in that part of the brain cannot function. When this happens the part of the body controlled by these nerve cells cannot function either. The result of a stroke may be, for

example, weakness or paralysis of one side of the body, inability to walk, loss of memory, or difficulty in speaking. These effects may be very slight or very severe. They may be temporary or permanent.

Strokes may occur from several different causes. Only a physician can accurately determine the cause of this stroke, although basically they fall into one of three categories. (1) Strokes occur when clotting forms in an artery in the brain or in the neck leading to the brain and the flow of blood through the brain tissue is restricted. (2) Strokes may occur when a hemorrhage or bleeding occurs as the result of a diseased artery in the brain which leaks or bursts. (3) A stroke may occur when a compression restricts the flow of blood in an artery. Compressions may be caused by brain tumors, or as the result of accidents.

While strokes are dangerous, many victims of strokes may be rehabilitated, according to the N. C. Heart Association. The degree to which a stroke victim may be rehabilitated depends on a number of factors. (1) The type of stroke suffered, (2) the degree of the damage to the brain, (3) and a large measure of the individual's willingness to be rehabilitated and his family's help in the rehabilitation.

THE HEALTH BULLETIN
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Printed by The Graphic Press, Inc., Raleigh, N. C.

NORTH CAROLINA HEALTH COUNCIL TO MEET DECEMBER 2 IN DURHAM

The 65 member N. C. Health Council has scheduled its Annual Meeting on Tuesday, December 2, in Durham. Representatives from the member organizations and agencies will participate in the one-day program at the Durham Hotel. Dr. Edwin S. Preston of Raleigh is president of this statewide organization and Dr. John McCain of Wilson is vice-president.

North Carolina is proud to have Margaret B. Dolan, professor and head of the department of Public Health Nursing in the UNC School of Public Health, as the newly-elected president of the National Health Council with which the North Carolina Health Council is affiliated.

Mrs. Dolan will be one of the feature speakers at the December meeting.

Throughout its 20 year history the N. C. Health Council has made many contributions to the improvement of health affairs in the state. Studies have been made, conferences held, and stimulus given to focus the conscience and efforts of the state's citizens upon the health needs—and with telling effect.

Last year's meeting was an outstanding success—and this year will be no different. All statewide organizations and agencies related to health will wish to be well represented in Durham.



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

AUGUST 1969

TESTING FOR GERMAN MEASLES — A scene in the Laboratory of the State Board of Health as 120 Laboratory Technicians from 35 hospitals from over the State were trained in the latest techniques used by physicians for diagnosis and control of German Measles (Rubella). Shown in the picture are: (standing) left—Mrs. Lois Jeffreys; right—Mrs. Sarah Safco. (seated) from the left—Miss Sue Bowman, Mrs. Hope Ferneyhough and Miss Alison Binns.



THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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Cover

A Laboratory Scene during the five Rubella Workshops conducted recently by the Virology Section of the Laboratory Division of the State Board of Health.



Featured Speakers at 58th Annual Meeting of N. C. Public Health Association in Asheville, September 17-19

**Left to right, top—Dr. Jacob Koomen and Dr. Lester Breslow.
Bottom—Dr. E. A. Pearson, Dr. Cecil G. Sheps and Dr. John J. Hanlon.**



North Carolina's Comprehensive Stroke Program

**Margaret R. Keller, R.N.
B. Lionel Truscott, M.D.**

The North Carolina State Board of Health recently released the report of vital statistics for 1968 that indicated 5,747 deaths from stroke, or an annual rate of about 115/100,000 population. The exact incidence and prevalence of this disease condition in North Carolina is difficult to determine but it is recognized that every community in this state has potential stroke patients or existing patients in various phases of the illness that need comprehensive and quality care. In 1967, the N. C. Regional Medical Program submitted a project for a Comprehensive Stroke Program which became operational in 1968. The objective of this program is to make available to the stroke patient the highest quality of comprehensive care.

In order to reach this objective, the program's focus is concentrated at the local level and involves local health facilities, health personnel and lay community leaders. Therefore, the first step to be taken is for a community to recognize that stroke patients living in their midst need improved care and

that the community itself, by marshalling their energies, talents, and resources can provide care that is comprehensive and continuous. This first step requires the participation of public health personnel in each county if a local stroke program is to materialize.

Four counties in North Carolina have recognized the need for a local stroke program and are committed to accomplishing the goal as set forth by the Comprehensive Stroke Program of the N. C. Regional Program. The role, contribution, and expertise from the local health departments have played an important part in making it possible to have stroke programs in these counties, namely: Ashe, Catawba, Surry and Vance.

One basic requirement to implement a local stroke program is a stroke coordinator who must be a local physician on the local hospital staff. Once this is determined, the director of the N. C. Comprehensive Stroke Program, Dr. B. Lionel Truscott, meets with this local physician and explains the necessary steps that need to be taken. This local physician then calls a meeting of a group of local people designated as ad hoc steering committee. This includes representatives from the hospital, usually one other physician, and hospital administra-

tor, the director of nursing services in the hospital and/or a nurse supervisor from the medical wards, the physical therapist from the local hospital, the director of the Department of Welfare, the director of the health department and the public health nurse supervisor or public health staff nurse. The staff from the Comprehensive Stroke Program office then meets with this steering committee and explains the next organizational steps. This committee then votes and makes the decision and commitment to implement a local stroke program.

Of the twelve counties that have been visited, four have been successful in having steering committee meetings, and three counties have appointed physician stroke coordinators and local stroke program committees. The local stroke program committee chairman may be a health professional or a lay person. The committee in Catawba County has designated the health director, Dr. Melvin F. Eyerman, as chairman of their committee. In another county, the local hospital administrator serves as committee chairman.

Further organization and committees are formed that include public health personnel. The in-service education com-

mittee which comprises the "local stroke team" that includes the physician, stroke coordinator, stroke hospital nurse, stroke community nurse and physical therapist are selected. In three counties, the stroke community nurse was selected from the local health department nurse staff. In fact, the recruitment was so successful that two public health nurses from each of these health departments are now participating in local stroke teams and program development. The third group of public health personnel that have participated are five of the eight physical therapy consultants from the Physical Therapy Section, Community Health Division. This group of consultants will assist local stroke teams in areas of the state where local physical therapists are not available thus making it possible for assessment and evaluation of physical therapy needs of stroke patients, as well as participating in local in-service education programs on Comprehensive Stroke Care.

Other committees that are appointed by the stroke program committee chairman are: Area Resource Development, Public Education and Discharge Planning. This last committee, Discharge Planning, is the key to an effective local stroke program and it is in this aspect of

the program that public health personnel can make a meaningful contribution. It is not enough that the stroke patient receive intensive care during the acute and post acute phase only to be returned to a nursing home, to their family and community and be forgotten. Re-admissions to the hospital for further treatment of preventable complications such as decubiti, contractures, or bladder infections can be avoided if discharge plans are made and follow up care provided. Public health personnel such as nurses, physical therapists, nutritionist, health educators, sanitarians are well versed on community aspects of health care both preventive and curative. Stroke patients and their families are members of and a part of a community who need care, counseling, and support that can be provided by combining the efforts and resources of all health personnel regardless of the institution, agency, or fiscal control.

The four counties that have ventured into this program and are in the formative stage have already created a mechanism for health personnel from hospitals, health departments and nursing homes to meet and work together toward a common goal. This merging of facilities, personnel and resources makes it

possible to identify gaps in service or duplication of services, develop new services or make better use of existing services. These communities also have Stroke Consultation Services made available to them from the Neurology Departments from the three medical centers in the State thus extending the medical expertise to local communities with limited diagnostic or laboratory facilities.

Some communities, particularly in the rural and sparsely populated areas of the state may feel that a local stroke program is not feasible, and that other health needs are more pressing or take higher priority. This, of course, is a local decision, yet, the basic organizational pattern as designed by the Comprehensive Stroke Program can be applied to any health problem area. The first step is often the hardest to take namely: to have an interested citizen who wants to do something about the problem. The physician stroke co-ordinators who took this first step are already busy medical practitioners with limited time to devote to this activity. The four counties that now have a local stroke program are fortunate to have local physicians who have started this program and the support and help from the local health departments is indeed encouraging.

Drug

Abuse

(Also "Drugs Made Plain"—
See next two pages)

Although there are no precise figures on the incidence of drug abuse in North Carolina, the problem appears to be increasing. Amphetamines are thought to be the drugs most commonly abused but barbiturates, paregoric, cough syrup with codeine, and hallucinogens, such as marihuana, are frequently misused. The number of persons using one or more of these is estimated to be in excess of 10,000 in North Carolina. Opiates, including synthetic agents, are much less frequently used and heroin was allegedly unknown to this state until two years ago.

To the present, no person or group has undertaken to identify, treat, or follow-up all cases of drug abuse in this state. Mental health clinics, mental hospitals, and presumably private and military physicians have offered the only treatment and for the most part, this treat-

ment has been short-term. The lack of long-term treatment facilities both in-patient and out-patient, is somewhat akin to returning a cured malaria patient to an endemic area without prophylaxis. The relapse rate is discouragingly high.

Where there is a demand, the "pusher", or vector of this disease, is ubiquitous. The State Bureau of Investigation estimates 10-20 such contacts in every large city in North Carolina.

From a legal standpoint, conviction for the use of and/or distribution of opiates, synthetics, and hallucinogens is a felony. First offense convictions for the use of and/or distribution of stimulants, barbiturates, and marihuana are misdemeanors. The conviction rate is high. Primary emphasis is placed on the identification of and conviction of the pusher.

Inasmuch as the complexity of drug abuse is great and inasmuch as there are, now, no wholly adequate agencies or facilities to deal with the problem in a comprehensive way, the General Assembly has, in 1969, ratified Senate Joint Resolution 567 which provides for the creation of a Study Commission. Hopefully, this Commission will be able to lead the way to progress in the control of this disease.

Drugs

ILICIT (PROHIBITED) DRUGS (Manufacture and distribution prohibited except for approved research)

	Slang names	What they are	How taken
HALLUCINOGENS	LSD, Acid	LSD-25 is a lysergic acid derivative. Mescaline is a chemical taken from peyote cactus. Psilocybin is synthesized from Mexican mushrooms.	In tablet, capsule, ampoule (ampoule) form or in saturated sugar cubes.
HEROIN	Snow, Stuff, H, Junk and others	Heroin is diacetylmorphine, an alkaloid derived from morphine; it does not occur in opium. A white, off-white, or brown crystalline powder, it has long been the drug of choice among opiate addicts. Its possession is illegal.	May be taken by any route, usually by intravenous injection.
MARIJUANA (Cannabis)	Joints, Sticks, Reefers, Weed, Grass, Pot, Muggles, Mooters, Indian hay, Loco-weed, Mu, Giggle-smoke, Griff, Mohasky, Mary Jane	Marijuana is the dried flowering or fruiting top of the plant Cannabis Sativa L., commonly called Indian Hemp. Usually looks like fine, green tobacco. Its possession is illegal. Hashish is a preparation of cannabis, taken orally in many forms.	Marijuana smoked in pipes, cigarettes. Hashish is infrequently rolled into candy, sniffed in powder form, mixed with honey for drinking or with butter spread on bread.

LEGITIMATE (PERMISSIVE) DRUGS (Essential to the practice of medicine; legitimate manufacture and distribution)

AMPHETAMINE	Bennies, Co-pilots, Footballs, Hearts, Pep pills	Amphetamines are stimulants, prescribed by physicians chiefly to reduce appetite and to relieve minor cases of mental depression. Often used to promote wakefulness and/or increase energy.	Orally as a tablet or capsule. Abusers may resort to intravenous injection.
BARBITURATES	Red birds, Yellow jackets, Blue heavens, Goof balls	Barbiturates are sedatives, prescribed to induce sleep or, in smaller doses, to provide a calming effect. All are legally restricted to prescription use only. Dependence producing, both psychic and physical, with variable tolerance. Signs of physical dependence appear with doses well above therapeutic level.	Orally as a tablet or capsule. Sometimes intravenously by drug abusers.
COCAINE	The Leaf, Snow, Speedballs (when mixed with heroin)	Extracted from the leaves of the coca bush. It is a white, odorless, fluffy powder that looks like crystalline snow.	A surface active anesthetic. Abusers, taken orally or, commonly, intravenously alone, combined with or snorting with heroin. The leaves are chewed with producing the effects of contained cocaine.
CODEINE	Schoolboy	A component of opium and a derivative of morphine, in most respects a tenth or less as effective as morphine, dose-wise.	Usually taken orally, in tablets for pain; or in a liquid preparation, of variable alcohol content, for cough. Can be injected.
METHAMPHETAMINE	Speed, Crystal	Stimulant, closely related to amphetamine and ephedrine.	Orally, as tablets or in an enema or intravenously.
MORPHINE	M, Dreamer, and many others	The principal active component of opium. Morphine sulphate: white crystalline powder, light porous cubes or small white tablets.	May be taken by any route. Abusive use is mostly by intravenous injection.

Plain

Temporary effect	How to spot abuser	Dangers
Induce hallucinations, exhilaration or depression, and can lead to mental changes, psychotic estiations, suicidal or homicidal tendencies.	Abusers may undergo complete personality changes, "see" smells, "hear" colors. They may try to fly or brush imaginary insects from their bodies, etc. Behavior is irrational. Marked depersonalization.	Very small quantities of LSD may cause hallucinations lasting for days or repetitive psychotoxic episodes, which may recur months after injection. Permanence of mental derangement is still a moot question. Damage to chromosomes, and hence potentially to offspring, has been demonstrated.
Morphine in all respects, faster and shorter acting.	Morphine-like.	Like morphine; dependence usually develops more rapidly. Dependence liability is high.
Ring of great perceptiveness and sure can accompany even small doses. Erratic behavior, loss of memory distortion of time and spatial options, and hilarity without apparent cause occur. Marked unpredictability of effect.	Abusers may feel exhilarated or relaxed, stare off into space; be hilarious without apparent cause; have exaggerated sense of ability.	Because of the vivid visions and exhilaration which result from use of marijuana, abusers may lose all restraint and act in a manner dangerous to themselves and/or others. Accident prone because of time and space sense disturbance. Dependence (psychic but not physical) leads to anti-social behavior and could be forerunner of use of other drugs.
are confined to ethical drug channels.)		
Small doses produce wakefulness, increased alertness and a feeling of increased initiative. Intravenous use produce cocaine-like psychotoxic effects.	An almost abnormal cheerfulness and unusual increase in activity, jumpiness and irritability; hallucinations and paranoid tendencies after intravenous use.	Amphetamines can cause high blood pressure, abnormal heart rhythms and even heart attacks. Teen-agers often take them to increase their "nerve." As a result, they may behave dangerously. Excess or prolonged usage can cause hallucinations, loss of weight, wakefulness, jumpiness and dangerous aggressiveness. Tolerance to large doses is acquired by abusers; psychic dependence develops but physical dependence does not; and there is no characteristic withdrawal syndrome.
Large amounts make the user relaxable, good-humored. Heavy doses make him sluggish, gloomy, times quarrelsome. His speech is thick and he staggers. Sedation coordination progressive with dose and at least additive with alcohol and/or other sedatives and tranquilizers.	The appearance of drunkenness with no odor of alcohol characterizes heavy dose. Sedation with variable ataxia.	Sedation, coma and death from respiratory failure. Inattentiveness may cause unintentional repetitive administration to a toxic level. Many deaths each year from intentional and unintentional overdose. Potentiation with alcohol particularly hazardous. The drug is addictive, causing physical as well as psychic dependency, and withdrawal phenomena are characteristically different from withdrawal of opiates.
It is said to relieve hunger and thirst, and produce some degree of exhilaration. Intravenous use produces marked psychotoxic effects, particularly with paranoid tendencies. Repetitive doses lead to mania, excitement, muscular twitching, convulsive movements.	Dilated pupils, hyperactive, exhilarated paranoid.	Convulsions and death may occur from overdose. Paranoid activity. Very strong psychic but no physical dependence and no tolerance.
It is a sedative and cough suppressant but very little sedation or exhilarant (psychotic) action. Dependence can be produced or partially supported, large doses are required and risk is low.	Unless taken intravenously, very little evidence of general effect. Large doses are morphine-like.	Occasionally taken (liquid preparations) for kicks, but large amount required. Contribution of the alcohol content to the effect may be significant. Degree and risk of abuse very minor. Occasionally resorted to by opiate-dependent persons to tide them over with inadequate result.
It resembles amphetamine but is less marked and toxicity greater.	Extreme restlessness and irritability; violence and paranoid reaction possible.	Excessive psychotoxic effects, sometimes with fatal outcome.
It is a sedative and analgesic (not excitatory). The initial reaction is unpleasant to most people, it calms supersedes and, depending on dose, may progress to coma or death from respiratory failure.	Constricted pupils. Calm, inattentive, "on the nod," with slow pulse and respiration.	Man is very sensitive to the respiratory depressant effect until tolerance develops. Psychic and physical dependence and tolerance develop readily, with a characteristic withdrawal syndrome.

Laboratory Training In German Measles Testing Given 120 Persons From 35 Hospitals

Laboratory technicians from 35 hospitals over the State were given training by the State Board of Health in the test which is used by private and public health physicians in the diagnosis and control of German Measles (Rubella).

Five workshops were held in the State Board's Laboratory Division. The Virus Section of the Laboratory offers this test and this training as a service to the physicians of the State in the interest of the people.

The classical form of Rubella, a mild viral disease often producing a rash, is usually not

complicated by more serious symptoms. However German Measles is known to be a dangerous disease when it is contracted during pregnancy, especially during the first three months. If the mother becomes infected the child most likely will become infected and deformities are the result. Twenty thousand deformed children are reported to have been the end result of a tremendous epidemic during 1964.

The workshops were conducted in cooperation with the National Communicable Disease Center in Atlanta, Ga., and the Continuing Education and Field Service of the School of Public Health, University of North Carolina at Chapel Hill. Mrs. Norma B. Carroll, Chief of the Virus Section, says that a program of evaluation is being planned to test the proficiency of the personnel who are performing Rubella serology.



Hemagglutination Inhibition Test — Treatment of Sera —
being conducted by Harold McCollon of the Forsyth County Health Department during the Rubella Workshops.



Participants in Five One-Day Workshops on Rubella.





One hundred and twenty persons from 35 hospitals were enrolled in Rubella Workshops.



The Longevity of United States Senators

From the
Statistical Bulletin
Metropolitan Life

Senate: literally a council of elders, from the Latin *senex*: elder. In this century United States Senators have indeed been more of a council of elders than those who served in the first 56 Congresses, but the life expectancy of those in office since 1930 has fallen signifi-

antly short of that for white males in the general population. During the 69 years that elapsed between the outbreak of the Civil War and 1930, the longevity of United States Senators closely approximated that of white males in the general population.

This conclusion is drawn from a study of the longevity of 1,619 men elected or appointed to the United States Senate from the time of the First Congress of the United States in 1789 through the First Session of the Ninetieth Congress to the end of 1966. During this 178-year period, 1,416 Senators died, 223 of them (about 16 percent) reportedly passed on while in office; four deaths were due to assassination, three resulted from duels, and one occurred in a Civil War battle. The nine women Senators who served during this period are not included in the study.

Expectations of life for the deceased Senators at the time of their first taking office were calculated on the basis of special cohort mortality tables for the white male population of the United States. Such tables, prepared in the Statistical Bureau of the Metropolitan Life Insurance Company, trace the changing longevity over the calendar years following each Senator's accession to office.

For white men born prior to 1840, it was assumed that mortality rates in the United States conformed substantially to those shown in the Wigglesworth Table and English Life Table No. 2. From 1840 on the mortality rates assumed were those developed by P. H. Jacobson in his paper "Cohort Survival for Generations Since 1840" (*Milbank Memorial Fund Quarterly*, July 1964) but with modifications designed to reflect the fact that since about 1955 the death rates of white males in the United States have shown virtually no change.

Over the entire period since 1789, the average duration of life of deceased Senators from the time they took office was 1.3 years less than might have

been expected on the basis of contemporaneous mortality rates in the general population. The longevity of Senators in relation to that of white males in the general population has varied considerably over the years, as shown in the accompanying table. The 571 Senators who took office prior to the Civil War lived on the average 2.3 years less than did the white males in the general population during the same period. By way of contrast, the Presidents who served before Lincoln lived on the average about .3 of a year longer than white males in the general population. The most favorable longevity record among Senators was achieved by the 392 men who took office between 1861 and 1900; they lived

Period of Taking Office	Number of Senators	Average Age on First Taking Office	Number Died Before End of 1966	Average Age at Death	Differences in Life Expectation*
1789-1860	571	45.4	571	68.5	-2.3
1861-1900	392	49.9	392	71.5	0.6
1901-1930	319	52.8	309	73.3	0.3
1931-1966	337	52.0	144	69.0	-5.9
1789-1966	1,619	49.3	1,416	70.4	-1.3

*This difference measures a) the average number of years actually lived by Senators from date of taking office to date of death, and b) the life expectancy of white males in the general population born in the same years as the Senators. The life expectancy in the general population for white men born prior to 1840 was approximated from available data, such as the Wigglesworth Table and English Life Table No. 2. For men born since 1840, it was based on figures developed by P. H. Jacobson, in his paper "Cohort Survival for Generations Since 1840," *Milbank Memorial Fund Quarterly*, July 1964, Part I, 42: 36-53, with modifications to reflect the relative stability of white male mortality since 1955.

on the average .6 of a year longer than white males in the general population during the same period. The 309 Senators who took office between 1901 and 1930 and died before the end of 1966 also on the average outlived white males in the general population, but only by an average of .3 of a year.

The 144 Senators who took office after 1930 had the poorest longevity record; they fell short of the contemporaneous life expectancy of white males in the general population by 5.9 years. This record may reflect the increased pressures on and the more onerous duties of our legislators in the depression years, during World War II, and over the period when the United States assumed global responsibilities.

The mortality rates among Senators since 1930 are actually more unfavorable than appears from the comparisons made with white males in the general population, because in the recent past Senators have more often than not been drawn from the higher socioeconomic segments of the population, which have experienced a mortality rate below that of all white males in the United States—about 10 percent lower in 1950. Even more pointedly, a

recent followup study of men in the 1950-51 edition of *Who's Who in America* indicates that prominent men have been subject to mortality rates as much as 30 percent below those for all white males in the general population; government officials (including Senators) within this group recorded death rates 20 percent lower than those of white males in the general population.

The average age at which Senators took office for the first time has increased over the years. Prior to the Civil War the average age of Senators was 45.4 years, rising to 49.9 years for the men who became Senators between 1861 and 1900. Since the turn of the century the average age of Senators has been about 52 years. Two octogenarians became Senators for the first time: Andrew Jackson Houston, of Texas, in 1941 at the age of 86, who died within two months, and John Wolcott Stewart, of Vermont, who assumed office in 1908 at the age of 82 and lived to be almost 90 years old. Senator Cornelius Cole of California, who was elected Senator in 1867 at age 44 and served one six-year term, lived to be 102 years old and thus holds the record as the longest-lived Senator.

THE HEALTH BULLETIN
P. O. Box 2091
Raleigh, N. C. 27602

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Printed by The Graphic Press, Inc., Raleigh, N. C.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health



September 1969

**HONORARY
ARTHRITIS
FOUNDATION
CHAIRMAN
NAMED**

THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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JACOB KOOMEN, JR., M.D., M.P.H., RALEIGH

JOHN C. LUMSDEN, B.C.H.E., RALEIGH

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M.A., LL.D.

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Cover

Jessie Rae Scott (Mrs. Robert W.) has been named Honorary Chairman of the Arthritis Foundation in North Carolina. Shown with Mrs. Scott is Robert Gregory Holland, 1969 Child of Hope.

Mrs. Scott

Named

Arthritis

Foundation

Chairman

Mrs. Robert Walter Scott has been named Honorary Chairman of The Arthritis Foundation in North Carolina to succeed Mrs. Dan K. Moore. The selection is announced by Dr. Donald D. Weir of Chapel Hill, chairman of the board of directors of the Foundation.

Dr. Weir stated: "It is a privilege to announce that our First Lady, Mrs. Jessie Rae Scott, has accepted the honorary chairmanship of The Arthritis Foun-

dation. We are grateful to Mrs. Dan K. Moore for having served in this capacity. Mrs. Moore will continue to serve as a sponsor for the North Carolina Chapter. Mrs. Scott's leadership will mean much to our work in North Carolina.

The First Lady is a native of Fayetteville and was raised in Swepsonville in Alamance County. She is a graduate of the University of North Carolina at Greensboro and a former teacher in the public schools. Mrs. Scott is an active member of Hawfields Presbyterian Church. She is also active in the P.T.A. and Home Demonstration Club work.

Governor and Mrs. Scott have five lively children who make the Executive Mansion very much a lived-in home. They are: twins, Mary Ella and Margaret Rose, 12 years old, Susan Rae, 11, W. Kerr, 10, and Janet Louise, 5. Another prominent member of the "family" is Duke, the famous gubernatorial dog.

The Arthritis Foundation is the only national health agency devoted to the problem of arthritis which afflicts amore than 400,000 North Carolinians. This oldest known crippling disease afflicts seventeen million Americans. The Foundation promotes research seeking to find the cause and cure of arthritis.

The N.C. Nursing Home Association

Seventy-four nursing homes, nursing centers and extended care facilities are members of the North Carolina Association of Nursing Homes which, in turn, is affiliated with the American Nursing Home Association.

Organized as a non-profit corporation, the Association offers the nursing home administrator what he cannot do as an individual to advance the interests of his facility. His membership provides him with representation at the State Legislature, with important health and welfare officials in State and Federal governments and with Medicare and Medicaid health programs. It gives edu-

cational workshops and meetings to inform the administrator and his staff of the latest procedures in administration, patient care, pharmacy, dietetics, housekeeping and other subjects necessary in nursing home operation. It distributes newsletters and bulletins to inform and aid in planning for the future. Its public relations activities purport to upgrade the image of nursing homes to the public and to other elements in the health field.

The president of the Association is C. J. Blanchard, Jr., administrator of The Evergreens, Inc., a non-profit nursing center at Greensboro. A graduate of the University of North Carolina at Chapel Hill, he was a hospital administrator at Wilson and, prior to that, on the staff of the North Carolina Medical Care Commission at Raleigh.

Vice presidents reflect the different types of facilities. Mrs. Sylvia X. Allen is an owner of a skilled nursing home at Fayetteville; Richard A. Short is administrator of a non-profit, church-owned facility at High Point; Mayo E. Allen is administrator of a Greenville nursing center owned by a nationwide nursing center corporation.

Executive director of the Association is John T. Kerr who has offices in Durham.

Nursing

Homes

Came About

In Response

To a Need

By

**W. Gordon Poole
and
Hugh G. Young**

The need for care of the aged has surely been recognized in all times; the inadequacy of civilization in meeting this need has been officially noted many times. Twenty-four hundred years ago Confucius included in his view of the perfect state the following:

"When the great way was practiced, a spirit of public welfare pervaded the world . . . Men did not love only their own parents, nor did they treat as children only their own sons. The aged were cared for until death."

The care received by the aged since then has varied, but never has it been adequate.

Institutional care for the aged in the United States began with small religious institutions developed to shelter elderly members of their own faith. In the nineteenth century some fraternal, trade and local civic organizations began establishing places of shelter, some of which offered some medical and nursing care. The development of this type of institution was slowed in 1913 by the establishment of the Federal Income Tax which made less money available for philanthropy.

During the first half of the twentieth century, some people took elderly persons into their homes; but as public funds were not available—and most of those in need of shelter had little or no money—growth was slow and medical care nearly non-existent.

After Social Security payments to the elderly began in 1940, there developed throughout the nation a movement toward sheltering recipients of these funds in private homes. The care offered was meager; and unless the home was that

of a professional nurse, nursing service was not provided. As the residents grew older, they also became sick or sicker. The financial resources and knowledge of the proprietors of these homes were inadequate to provide even basic care for the thousands of elderly sick.

In North Carolina the Department of Public Welfare began licensing institutions for the aged in 1945. As the need for medical services became more obvious, the North Carolina Medical Care Commission began licensing nursing homes in 1955. This followed the 1950 Social Security Amendments which made federal funds available for the care of persons in facilities licensed by the State. A boom in nursing home construction followed the enactment of the 1950 amendments.

In 1961 the North Carolina State Board of Health assumed the licensing responsibility of all nursing homes not under the same management as a hospital. The Medical Care Commission continues to license nursing units operated by or in conjunction with, a hospital.

The nursing home is an infant in the health facility field. In the 1950's, when the nursing home, as we know it, was born, the Hospital was well established. As with any infant, there are, and will continue to be, growing pains, but to be honest in our appraisal of the nursing home field today, we must re-

member that it has come a remarkably long way in the past few years. For the most part this growth and improvement has been without any master plan, and it has in many instances been without the support of the local communities. Very few communities have taken it upon themselves to establish first class nursing homes for their people.

The effort for improved and sufficient nursing home care has come primarily from religious affiliated groups and private providers. Today in North Carolina many non-profit and proprietary homes are providing excellent care, with the proprietary interests providing by far the largest percentage of beds.

Federal Legislation Helps

Recent federal legislation is making an impact upon nursing homes. Amendments to the Social Security Laws established Title XVIII and Title XIX of the Social Security Laws. Title XVIII is commonly referred to as Medicare and is a Health Insurance Program for the elderly. Title XIX is commonly referred to as Medicaid and is a program of medical assistance for those unable to pay the high cost of medical care from their own funds.

Medicare and other factors have brought about the establishment of public corporations specializing in nursing home

activities. These homes for the most part provide long term care and extended care benefits that are reimbursable by the Social Security Administration under the Medicare Provisions. The facilities, for the most part, are larger than those existing prior to Medicare. All nursing homes must meet State licensure standards and only Medicare certified homes must meet the Conditions of Participation in the Medicare Program. They provide services that normally are needed by those recuperating after a hospital stay.

Title XIX, or Medicaid, has not yet been put into effect in North Carolina, but it is expected to be implemented January 1, 1970. The Medicaid program will replace the present method of public assistance reimbursement for those needing nursing home care. Homes participating in this program must be certified to meet the statutory requirements of Title XIX and must meet State licensure standards also.

Many homes will participate in both Medicare and Medicaid. Other homes will participate in neither program, although they meet the certification requirements.

Presently, there are over 107 nursing homes in North Carolina providing more than 6,000 beds licensed for skilled nursing care. The size varies from 5 beds to 288 beds. Most new

homes built today will have 50 or more skilled nursing beds.

All of the homes now operating meet the facility requirements of the State Building Code and of the Rules and Regulations for the Licensing of Nursing Homes. The services provided in these homes vary with the needs of the patients accepted. The homes are inspected on a regular basis by personnel of the State Board of Health for compliance with the Rules and Regulations for Licensing of Nursing Homes as relating to administrative, nursing, therapeutic, dietary and other services.

Of special interest is the fact that more and more nursing homes are providing physical therapy for their patients. This therapy is prescribed by a licensed physician and is under the direction of a Registered Physical Therapist. Staff personnel supervised by a registered physical therapist can perform many activities which are helpful in rehabilitating the patient.

Another activity which is increasing is that of organized recreational therapy. Many nursing homes have recreation programs under the direction of an Activities Director. These programs are designed to stimulate the interest of the patient and are of a type that patients with various restrictions can enjoy.

Nursing Service Is Of Primary Concern

Of primary concern to the nursing home is the nursing service. In North Carolina each home providing skilled nursing care must have twenty-four hour professional nursing coverage under the direction of a registered nurse. Patients must be admitted by a physician, and the nursing personnel must carry out the care prescribed by the physician. Medical records documenting this care must be maintained. Many patients who cannot benefit from extended hospitalization can receive excellent nursing care which meets their needs in the nursing home.

The cost of nursing home care is less than half that of hospital care; therefore, it is important to all concerned that persons who cannot benefit from the care offered in an acute general hospital, but who can be cared for in a skilled nursing home, should be placed in the nursing home as soon as possible.

In the future, in order to promote better utilization of health resources, some new types of institutions will be developed. To a great extent, efforts of the federal government are making a difference between "skilled nursing care" and "intermediate" or minimum nursing care. There will be less mixing of

patients having a real need for skilled nursing care and those needing less intensified care. The skilled nursing home will only care for those who can benefit from such services, just as the hospital will care only for those who can benefit from its services. Homes designed and staffed for domiciliary care will not house patients needing nursing care.

The intermediate care facility, with a registered or practical nurse on duty on the day shift only, will become very popular and will offer care to the thousands who cannot benefit from twenty-four hour skilled nursing care, but who do need professional assistance and observation. Many nursing homes will provide several types of care in distinct units of the home. As an example, a home could have a skilled nursing care unit which may be certified for Medicare and Medicaid, an intermediate care unit and a domiciliary unit. Retirement homes and villages will likely offer this type of arrangement.

It is unlikely that in the years ahead the number of health personnel will increase rapidly enough to relieve the current shortage of nursing and other skilled personnel. This problem will become more severe as staffing requirements increase for skilled nursing homes as the homes accept only those who can benefit from the services

offered. However, many patients may be cared for in the homes offering less intensified care thus allowing the professionals to see more persons needing their services, and thereby bringing an improvement in the physician-nurse to patient ratio.

The trend which is well under way now for caring for patients in the recuperating stages will increase as the facilities become better staffed and more sophisticated. By having a close physical relationship with a hospital, some skilled nursing homes will receive patients prior to hospital treatment. As an example, a patient may reside in the skilled nursing home for tests and preliminary work up—move through a connecting passageway to a hospital for surgery—and soon return to the nursing home for recuperation. It is noted that the nursing home need not be under the same management as the hospital for this arrangement to be effective.

As the homes become more proficient, there will be added acceptance by physicians, other health personnel, and the public in general.

In the future the various pre-payment and insurance plans will permit not only payment in but will encourage the use of skilled nursing homes that are adequately staffed and that maintain a close physician relationship. These homes provid-

ing a high quality service will relieve the hospitals of some of the needless demands for their beds. As the public searches for high quality they will go only to those homes meeting their demands for service and others will not survive.

Better medical knowledge of today and in the future will bring about a healthier as well as a larger aged population who will need increasing short term hospital care. In the future the general organization of nursing homes and their physical facilities will be continually improved. All activities of the nursing home will become better organized, more efficient and closely related to the patient's needs. There will be increased physician control over the care of the patients in skilled nursing homes. The nursing staff will be more thoroughly trained through institutional courses and through organized and regular in-service training programs. The dietary department will be professionally organized to provide restricted and modified diets as well as nourishing meals. The administrator will be a licensed nursing home administrator with special training.

Much knowledge has been gained over the past few years in the construction and arrangement of the physical plant. A great amount of knowledge that has been gathered will be put into use at an increasing rate

in the next few years. The physical plant will become more functional without losing its warmth.

Many of the characteristics of the nursing home in the future years are found in our nursing homes today. The seventies, for the most part, will bring a gradual increasing quality of care. The nursing home is presently

playing a very vital role in the health community. It is relieving the very expensive hospital facilities of needless demands. It is providing excellent recuperative and long term care for thousands of our citizens.

Long live the nursing home! May it become even more healthy!

Lambda Chi Alpha Men Support Arthritis Foundation

In 1968 the members of Lambda Chi Alpha social fraternity at the University of North Carolina in Chapel Hill voted to adopt The Arthritis Foundation as their special service project. They now con-

duct an annual Gymkhana to raise money for the Foundation.

This year the UNC-CH men sought the support of all 176 of their local chapters for the Arthritis Foundation. The chapters at North Carolina State University and Wake Forest University conducted a number of projects in Raleigh and Winston-Salem. Nationally about 100 chapters conducted projects.



A very active group of volunteers is the Lambda Chi Alpha Fraternity. Shown above, from left to right with the First Lady are: J. Edwin Conrad of North Carolina State University Chapter; Robert B. Wilson, Wake Forest University Chapter; Mrs. Scott; Greg, 1969 Child of Hope; John C. Dabney, Jr., University of North Carolina at Chapel Hill Chapter; and John H. Haynie, University of North Carolina at Chapel Hill Chapter.

Rocky Mountain Spotted Fever

Once again, this disease caused by Rickettsia rickettsii and transmitted here usually by the dog tick is causing significant morbidity and probably mortality. In North Carolina this year, several cases have already been reported.

Illustrative of the problem is

the occurrence of six known cases in Rowan County in the past month. All cases were in children, five of the six having a history of a tick bite. Several had easy access to woods and several had pets which could have acted as the carrier. They live in scattered parts of the county. The clinical picture was as usual: fever, myalgia (often sore neck), headache, and, on about the third day of illness, a macular or maculopapular rash beginning over the wrists and ankles and progressing to involvement of the entire body. Leukopenia was common, the Weil-Felix reaction was too non-specific to be of any value, but significant rises in complement fixation titer for specific R.M.S.F. antibodies were demonstrated in five of the six patients. All were treated relatively early with the drugs of choice, tetracycline or chloramphenicol, and all recovered, most with a minimum of difficulty.

Since North Carolina is among the top three or four states with regard to incidence of this disease, since it is easily confused with other exanthematosus diseases, is sometimes not considered in the differential diagnosis, and is fatal in about 10-20 percent of untreated cases, this brief reminder hopefully will serve some purpose.

Theme

"Investment in Tomorrow — The Whole Family"

**TWENTY-SECOND ANNUAL CONFERENCE
NORTH CAROLINA FAMILY LIFE COUNCIL, INC.**

October 2, 3, 4, 1969

Goldsboro Motor Hotel

Goldsboro, North Carolina

Thursday, October 2, 1969

4:00 Registration begins

7:00 First General Session

Terrace Room

Presiding

Dr. Lester D. Keasey
President, N.C.F.L.C.

Keynote Address

"The Generation Gap"

Dr. Elizabeth D. Koontz
Director, Women's Bureau
U. S. Department of Labor

Address

Dr. Carl Clarke
University of Florida

9:15 Reception

Friday, October 3, 1969

9:00 Annual Business Meeting

9:45 Second General Session

Address

"Socialization for the Seventies"

Dr. Betty E. Cogswell
Assistant Professor
Carolina Population Center
University of North Carolina at C.H.

10:30 Panel Discussion of Dr. Cogswell's Address

1:30 Third General Session

Address "Developing Citizenship for
Tomorrow's Youth"

Mr. James Luce
State Director of the N.C. Council
of the National Council on Crime & Delinquency

2:45 Workshops

1. Positive Interaction Counseling
2. Family Concerns of Military Personnel
3. Position Paper on Day Care Centers
4. Sex Education in the Home
5. Tour of O'Berry Training Center for Retarded Children
6. Tour of Cherry Hospital

7:00 Sperry Award Banquet

Address Dr. Sam Byuarm
Chairman, Social Studies Division
Johnson C. Smith University, Charlotte

9:00 Reception

Saturday, October 4, 1964

9:00 Fourth General Session

Two addresses — speakers not yet confirmed

12:30 Board of Directors Luncheon

Tetanus Not Always From Puncture Wounds

The belief that tetanus is most commonly associated with puncture wounds — classically, stepping on a rusty nail — might bear revision upon consideration of recently published national tetanus surveillance data for 1967.

Of the 195 non-neonatal cases of tetanus with a known outcome reported to the National Communicable Disease Center that year, fifty-five (28.2%) were associated with puncture wounds, but fifty-eight (29.7%) were associated with lacera-

tions. Miscellaneous wounds — including cutaneous ulcers, infected ingrown toenails, and even a "wasp bite" — accounted for the next largest category of injuries associated with tetanus (twenty cases; 10.3%). Fifteen cases (7.7%) had no known associated injury and fourteen cases (7.2%) were associated with abrasions. Six other categories account for the remaining thirty-three cases.

In only one case was there a history of adequate immunization by presently accepted standards. Data are presented which emphasize that a single "booster" dose of tetanus toxoid without an adequate history of a primary series cannot be expected to protect against infection with *Clostridium tetani*.

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Theodore D. Scurletis, M.D.	<i>Director, Personal Health Division</i>

Up-Dating

Hospital Care

There is an imperative need for an updating of the Hill-Burton Act, the Nation's basic hospital-assistance program.

When the Hill-Burton Act was adopted, the country suffered from a tragic shortage of rural hospital facilities. Many families living in rural areas had no facilities for lifesaving care available to them. Congress remedied that imbalance and inequity, largely through Hill-Burton funds, and did it so successfully that the Under Secretary of Health, Education and Welfare could testify recently that "today, despite rapid population growth, 90 per cent of the Nation's need for general hospital beds is fulfilled."

Indeed, the situation has been in a significant sense reversed. Today, as Senator Kennedy pointed out recently, "the most important single area in which new legislation is essential is the provision of greater Federal financial assistance for the construction of hospitals and other medical facilities in our major metropolitan areas." The prior-

ities of the 1940s, in short, are not the same as the priorities of the 1970s.

Two vital developments are needed. The formula for allocation of Federal hospital aid ought to be based on population, per capita income and need. Such a formula, which the proposed amendments prescribe, would correct a long-standing inequity in the distribution of aid.

Almost equally important is a proposed amendment designed to expand other kinds of medical facilities that would reduce the pressure on hospitals and so help to cut skyrocketing medical costs. There is a crying need for community diagnostic and treatment facilities to meet the health needs of low-income city dwellers. These could do a great deal to forestall a subsequent need for hospitalization. Another proposed amendment which seems to make admirable sense would correct the allocation of funds between new construction and modernization programs to enlarge the latter and diminish the former.

Dr. Charles Mayo of the Mayo Clinic once observed that "sickness makes people poor, poverty makes people sick." The interaction is indisputable. Health facilities are needed wherever poverty is prevalent.

Washington Post

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Printed by The Graphic Press, Inc., Raleigh, N. C.

IMPORTANT MEETINGS

October 11, 1969	American Association of Public Health Dentists, New York City
October 12-16, 1969	American Dental Society Meeting, New York City
October 14-17, 1969	Regional Conference on Coordinated Training Activities for Health Manpower, Particularly in Fields Relating to Medicare and Medicaid, Roanoke, Virginia
October 18-23, 1969	American Academy of Pediatrics, Chicago, Illinois
October 20-24, 1969	North Carolina State Nurses' Association, Raleigh, North Carolina
November 4-9, 1969	American Nursing Home Association, Houston, Texas
November 9-14, 1969	American Association of Public Health Physicians, Philadelphia, Pa.
November 10-14, 1969	American Public Health Association Philadelphia, Pa.
November 10-14, 1969	Association of Management in Public Health, Philadelphia, Pa.
December 2, 1969	N. C. Health Council — Annual Meeting, Durham, Hotel Durham
May 5-8, 1970	Southern Branch, APHA Memphis, Tennessee



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

October, 1969

North Carolina Public Health Association Holds Successful Session



Shown above are the 1969-70 officers of the North Carolina Public Health Association. From left to right they are: Mrs. Maxine S. Matheson, Treasurer; Dr. E. A. Pearson, Jr. Past President; Mrs. Jean Lassiter, President Elect; C. Scott Venable, President; Miss Jane Davis, Secretary; and Dr. Luby T. Sherrill, Vice President.

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Inside

A Better Life Through Better
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Pictures of Principal Award
Winners at Annual Meeting
of NCPHA.

Editorial Board

JOHN ANDREWS, B.S., RALEIGH

JACOB KOOMEN, JR., M.D., M.P.H., RALEIGH

JOHN C. LUMSDEN, B.C.H.E., RALEIGH

Guest Editor: Edwin S. Preston,
M.A., LL.D.

Vol. 84 October, 1969 No. 10

Also

25 Year Service Pin Winners
and Their Pictures.

Reminder of Annual Meeting
of N. C. Health Council to be
Held in Durham December 2.

Cover

The new Officers of the North
Carolina Public Health Associa-
tion.

A Better Life Through Better Health

Presidential Address

NORTH CAROLINA PUBLIC HEALTH ASSOCIATION

58th ANNUAL MEETING,

GROVE PARK INN,

ASHEVILLE, N. C.

September 17-19, 1969

**E. A. Pearson, Jr., D.D.S.
President**

HISTORY bears vivid testimony that the North Carolina Public Health Association is a working organization whose members are dedicated to the cause of better health for all North Carolinians.

(Perhaps) no other professional association can claim as many different health disciplines and specialty groups among its membership. It is truly a well coordinated, multidisciplinary organization. Since it was organized in 1911—58 years ago—growth and accomplishments have been the most evident characteristics. Growth is evidenced by the total membership roster which today numbers over 1700. This shows a very healthy increase over the

76 members who comprised the association in 1911. From 1911 until 1940, only public health physicians were members, and there was only one section. In 1940 the association changed its membership requirements to permit other health disciplines to join. Nursing, Sanitation, and Secretarial and Statistical were added as sections at that time. Today our sections number thirteen.

Our strength is not manifested in the sheer number of members but in our common goal which is singular in purpose—"a better life through better health." Each public health worker is dedicated to this important objective and plays a most valuable role in its a-

chievement. The total of these individual efforts has produced an enviable record of accomplishments as reflected in the improved health of our citizens. In almost all respects, North Carolina citizens are much better off today than they were 50 years ago. This does not imply that everything has been done that can be done to improve health. From experience and knowledge gained through research and improved techniques, we should be ready to launch out on the next fifty-year period with renewed interest, enthusiasm, and dedication to the task of eliminating the last vestiges of communicable diseases and improve the social,

mental, and physical environments whereby man can enjoy a more healthy, contented, and leisurely life than ever before.

Change Is Required

To consider accomplishing even to a small degree this noble objective, a change will be required. This would mean a change in attitude, change in habit, and a change in knowledge, not to mention a host of others. Change is not a new word to the public health worker, nor is the actual experience of undergoing change. It is almost an involuntary event which permeates our daily lives. We don't always like the changes which occur, and sometimes we hesitate before accept-



The Distinguished Service Award—the award to individual non-members of NCPHA for outstanding service to public health in North Carolina is presented to Mr. Charles A. Cannon, Concord.

ing them. Change occurs, however, regardless of how one may feel toward it. Change is necessary for healthy growth and development—in individuals as well as organizations. The North Carolina Public Health Association has changed through the years and must continue to change in order to more effectively meet new problems and conditions. We must be willing to accept change and to offer the best in leadership for the molding of guidelines

and in directing the course in which our actions will lead us. A ship without a rudder will soon flounder on the shores.

After beginning my tenure as President of the NCPHA, I became immediately concerned with the many committee appointments and work of the association. Without the benefit of experience as a president-elect, I had to perform my homework rather rapidly. I reviewed the present Constitution and Bylaws in an attempt to

NCPHA Honor Awards for 1969

Honor Awardees, for 1969, selected from available nominations are as follows:

Carl V. Reynolds Award

Group Merit Award

Watson S. Rankin Award

Merit Citation

Distinguished Service Award

Miss Nettie Lee Day, Raleigh

**North Carolina Conference of
Health Directors**

**Dr. Lucy S. Morgan, Chapel
Hill**

**Mr. Robert Miller McDaniel,
Rutherfordton**

Mr. Ray Small, Hickory

**Dr. Eugene Ramsey Hardin,
Robeson County**

**Mr. Charles A. Cannon, Con-
cord**

**Dr. Margaret White Battle,
Rocky Mount**

Respectfully submitted,

Dr. W. Fred Mayes, Chairman

Dr. Jacob Koomen

Dr. Martin P. Hines

Miss Anne Parrish

Mr. J. M. Jarrett

Miss Mary Edith Rogers

Dr. E. A. Pearson

Mrs. Betty Briggs



Dr. Alfred G. Siege, Moore County Health Director, accepts the Group Merit Award for the North Carolina Conference of Health Directors. Dr. E. A. Pearson, Jr. is shown on the right as he congratulates Dr. Siege.

gain a clear understanding of the rules and regulations pertaining to the proper procedure in the appointment of the various committee members and chairmen. This proved to be a very difficult task. It was evident that there were several parts of the document which needed to be changed in order to clarify and provide a more workable guide for the association. I realized that if the Constitution and Bylaws were changed, the Manual of Procedure would necessarily have to be changed. These matters were discussed with members of the association and of the Executive Committee, most of whom concurred with me regarding the needed changes. With this support, I appointed a Constitution and Bylaws Committee. The charge to the com-

mittee was as follows:

To study the stated objectives of the North Carolina Public Health Association as contained in the present Constitution and Bylaws and the Manual of Procedure for the purpose of:

- (1) Determining if the objectives (as stated) are sufficiently broad enough in scope, purpose, and flexibility to permit conformity in the ever-changing programs and procedures in the public health field in North Carolina.
- (2) Defining the NCPHA. (Example: Is the association an arm of official and voluntary health agencies created for their primary interest? Or, is the NCPHA an association created for the mutual benefit of its in-

dividual and collective membership?)

- (3) Determining if the present standing committee structures, composition by disciplines, methods of appointment, and geographic distribution are conducive to effective and efficient management and productivity.
- (4) Defining the duties of the officers of the association, specifically the duties of the President as relates to appointment of members-
- (5) Determining if the present method of financing the association is adequate in view of continuing rising costs (meeting facilities, NEWSLETTER, speakers, etc.).
- (6) Combining the functions of two or more committees into one committee function.
- (7) Determining if the present method of handling committee reports and resolu-



The Carl V. Reynolds Award—the highest award made to an individual member of the association, was presented to Miss Nettie L. Day, Chief of the Accident Prevention Section, N. C. State Board of Health. Shown are Dr. W. Fred Mayes, Dean, School of Public Health, University of North Carolina at Chapel Hill who presented the award, Miss Day, and Dr. E. A. Pearson, President, N. C. Public Health Association.

tions is the most effective to provide implementation and follow-up and in keeping the membership informed of current activities within the association.

- (8) Determining the effectiveness and feasibility of representatives from the NCPHA to other councils or associations and branches (liaison or official). What is the value of such liaison to the NCPHA?
- (9) Determine what is the authority of the Governing Council. Authority is used in the context of duties, responsibilities, process of

function, and relationships. Just what action can the Council take regarding reports from standing or special committees? Can they change the reports; take unfavorable action?

You will hear this committee's report later this morning. I urge you to be present and participate in this presentation. I have read the report and commend it to you as the official guide of our association. I hope you adopt the proposal.

Being a multi-disciplinary association has its advantages and disadvantages. As such, our association has membership rep-



The Watson S. Rankin Award—The award for recognition of outstanding contributions in public health in North Carolina over a period of many years was presented to Dr. Lucy S. Morgan, Chapel Hill.

The Merit Citation was presented to Dr. Eugene Ramsey Hardin, for outstanding work as full-time public health worker.



resenting every facet of the health field; that is, those who provide direct and indirect health services, those who provide services which are mandatory (e.g., water, food, and air), those who teach, and those who consult. The type agency or institution where members work also affords advantages or disadvantages, as the case may be, either local, state, or regional; voluntary or official, or quasi-official. One does not have to look far within our ranks to find an expert in any given field of health.

Committee Membership Demands

I have mentioned before that the NCPHA is a working organization. The association

makes demands upon its members to serve as committee members and officers in addition to their normal duties. When the time comes for appointments to the various committees, it is often difficult to get ready responses to the call for service from the membership at large. It is easy for selections to be made for these committee assignments from among persons who may be employed with the State Board of Health, the School of Public Health, or volunteer agencies. Not that there are objections to this procedure; but if such practice is followed year after year, eventually the committee structure will be heavily represented by persons from a limited number

of agencies or institutions. Committee membership should be evenly divided among the entire membership. Each member should have equal opportunity to serve the association and should voluntarily seek to serve rather than wait for a request to be extended. The fact that we are "busy people" is no excuse for not devoting to the association a portion of our time and talents. We do not want our association to become too heavily oriented toward either

agency or institution but rather a diffuse representation from all geographic areas and disciplines. The NCPHA is an association for all public health workers, and as such, must provide an equal opportunity for each person to serve. The NCPHA is among the largest state public health associations, and I believe ranks among the strongest. We want to make it *larger and stronger*. We are far short of our real potential. We have an opportunity to almost



The Merit Award—the award to individual members of the NCPHA who are doing outstanding work in their roles as full-time public health workers. This citation was given to Mr. Ray Small of Hickory.



The Watson S. Rankin Award for recognition of outstanding contributions in public health in North Carolina over a period of many years was presented to Mr. Robert Miller McDaniel. Dr. E. A. Pearson, President of N. C. Public Health Association congratulates the recipient.

double our present membership. There are many workers in the official and volunteer agencies who are not members of either the state or affiliated branches. I firmly believe that the Membership Committee, with very little effort, could increase our membership by 25 percent within the next year.

Annual Meetings Present Problems

Financing has been a problem and will continue to be a problem of even greater magni-

tude with the continuing increase in operating costs. Due to the large membership and thirteen sections, it is becoming increasingly difficult to find a facility sufficiently large enough to accommodate our convention needs (rooms for living and rooms for the thirteen section meetings which run concurrently). There are indications that in the near future the cost of convention facilities will rise sharply. The host cities which now afford facilities cap-

able of housing our Annual Meeting number six. The local health department in these six cities has assumed the arrangements for the convention. We are making too great a demand on them although we are most grateful for their gracious hospitality and willingness to do so much work for the association.

The association has been blessed thus far with good scientific programs. The General Session speakers have appeared with little or no remuneration. Can we expect this trend to continue? I think not! We should provide funds to cover these expenses without having to resort to the registration fee. There are ways of obtaining revenue for associational expenses other than the registration fee or dues. I refer to commercial exhibits, which, if properly solicited and managed, could perhaps provide sufficient funds to offset the cost of the annual convention program.

It occurred to me that there were opportunities for expanded and beneficial services to public health through the co-ordinated efforts of two important committees, namely, the Legislative Committee and the Committee to Study Personnel Problems. I volunteered this

opinion to the chairmen of these committees who agreed that the two, working in a more co-ordinated manner, would produce valuable results for the association and its membership.

I will give one example: The chairman of the Committee to Study Personnel Problems should serve on the Legislative Committee in order to keep abreast of things that transpire in this committee. The chairman of the Committee to Study Personnel Problems would also be the liaison representative from the NCPHA to the State Personnel Board. Thus, from his own committee (to study personnel problems), he could carry recommendations directly to the State Personnel Board for action. Being on the Legislative Committee, he could propose legislation to support personnel recommendations. With an active Legislative Committee, our association can support legislation at both state and federal levels.

By the same token, we can take issue with proposed legislation which the association feels is not in the best interest of the people of North Carolina. Our Legislative Committee has been very active this year. The General Assembly of North Carolina felt the impact of this committee's efforts as reflected

in the letters and acknowledgments from members of the General Assembly. We can and should enlarge on this potential. We can be much stronger by being active and alert.

Our membership in the North Carolina Legislative Council affords another opportunity for us to be heard. The Association stands to benefit from the Council's action regarding legislation which we support or oppose. I am speaking of legislation which affects the health interests of our citizens as well as legislation affecting appropriations and programs. We should not be reluctant to become involved in programs which may have political overtones. The day has passed when one can truthfully say that there is no politics in the health field. We must all become politicians of a sort if we are to survive in this fast and ever-changing world.

I would like to make one recommendation before closing:

I would propose establishing a resolutions committee whose function would be to handle all recommendations emanating from standing or special committees, or sections of the NCPHA. All recommendations would be submitted at least 30 days prior to the Annual Meeting. The committee would study

these resolutions as they relate to the association's activities. After careful study, the resolutions committee would prepare a report of all resolutions received and present it to either the Executive Committee or the Governing Council with appropriate recommendations. The Council or the Executive Committee would take action concerning the resolutions and recommendations submitted, after which, they would be referred to the proper committee or section for follow-up.

The comments made have in no way been intended to express criticism of the association's glorious past. Rather, they have been intended to focus attention to the areas within our association which I believe we should strive to strengthen, and by so doing, greatly assist in attaining the goal we are endeavoring to achieve—"a better life through better health."

Road blocks to the development of Health Manpower will be Presented and Discussed at the Annual Meeting of the N. C. Health Council in Durham on Tuesday, December 2.

N. C. Public Health Association - 1969

25 Year Service Pins

Adams, Luna G. (Mrs.) Nurse, Wake County Health Department—Ader, O. L. (Dr.) Health Director, Durham County Health Department—Askew, Edna H. (Mrs.) Clerk, State Board of Health—

Battle, Jennie W. (Mrs.) Nurse, Edgecombe County Health Department—Beckwith, Margaret S. (Mrs.) Administrative Secretary, Wake County Health Department—Black, Hester (Miss) Typist, Pender County Health Department—Bloodworth, Amelia R. (Mrs.) Nurse, Cumberland County Health Department—Burris, Rebekah J. (Mrs.) Nurse, New Hanover County Health Department—

Cahoon, Olive, (Mrs.) Typist, Hyde County Health Department—Clark, Nat T. (Mr.) Sanitarian, Buncombe County Health Department — Coble, Louise P. (Mrs.) Nurse, Sampson County Health Department

Drake, B. M. (Dr.) Health Director, Gaston County Health Department—Baker, Maude K. (Mrs.) Nurse, Gaston County Health Department—

Ferrell, Elizabeth D. (Mrs.) Wilson County Health Depart-

ment—Foster, Frances (Miss) Medical Laboratory Technician, State Board of Health—

Harris, Sue M. (Mrs.) Nurse, Scotland County Health Department—Hinkle, Jessie S. (Mrs.) Typist, Davie County Health Department—

James, Luella B. (Mrs.) Nurse, Robeson County Health Department—

Kent, Rosemary M. (Dr.) School of Public Health, UNC—

Larsh, John E., Jr. (Dr.) School of Public Health, UNC—

Lopp, Lucy (Miss) Nurse, Guilford County Health Department —Lundy, Esther B. (Mrs.) Accounting Clerk, State Board of Health—

McMahan, Elizabeth L. (Mrs.) School of Public Health, UNC—Matheson, Maxine S. (Mrs.) Medical Laboratory Supervisor, State Board of Health —Miller, Mildred C. (Mrs.) Nurse, Buncombe County Health Department—Mitchell, Gladys C. (Mrs.) Nurse, Wayne County Health Department—Monroe, Alice K. (Mrs.) Nurse, Burke County Health Department—

Pearce, T. H. (Mr.) Sanitarian, Franklin County Health



Department—Peeden, Anne (Miss) Typist, State Board of Health — Pollard, Sallie S. (Mrs.) Laboratory Technician, State Board of Health—

Rankin, Eugenia W. (Mrs.) Nurse, Gaston County Health Department—Register, Myrtle D. (Mrs.) Harnett County Health Department — Rogers, Mary Lois (Mrs.) Nurse, Durham County Health Department

Small, Ray (Mr.) Sanitarian, Catawba - Lincoln - Alexander District Health Department—Smith, Edna B. (Mrs.) Nurse, Robeson County Health De-

partment—

Taggart, Julie L. (Mrs.) Nurse, Rowan County Health Department—

Tesseneear, Clara (Mrs.) Supervisor, State Board of Health

White, Charlotte W. (Mrs.) Nurse, Buncombe County Health Department — Williamson, Ethel (Mrs.) Nurse, Mecklenburg County Health Department — Williford, Dorothy (Mrs.) Nurse, Northampton County Health Department—Woodlief, G. W. (Mr.) Sanitarian, Vance County Health Department.

N. C. Health Council Annual Meeting

Durham Hotel, Durham

Great Program — Dec. 2 — 10 AM - 4 PM

THE HEALTH BULLETIN
P. O. Box 2091
Raleigh, N. C. 27602

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N.C. DENTAL SOC.
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RALEIGH, N.C. MORDECAI S

If you do NOT wish to continue receiving The Health Bulletin, please check here and return this page to the address above.

Printed by The Graphic Press, Inc., Raleigh, N. C.

Representatives of 65 statewide organizations and agencies active in all phases of health will gather Tuesday, Dec. 2, in Durham for the Annual Meeting of the N. C. Health Council.

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E. A. Pearson, Jr., D.D.S., M.P.H.	-----	<i>Director, Dental Health Division</i>
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Ben Eaton, Jr., A.B., LL.B.	-----	<i>Director, Administrative Services Division</i>
Theodore D. Scurletis, M.D.	-----	<i>Director, Personal Health Division</i>



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

Thought For Today

Strangely enough the door to hope (in the future of the U.S. and the world) has been opened (via the flight of Apollo 11) by the very acme of s q u a r e d o m . . . three middle-aged American technicians of magnificent courage and very little color, whose curt, pragmatic language under stress was the very antithesis of the flamboyance youth fancied that it craved. Apollo's adventures have demonstrated that discipline, intellectual precision and a willingness to work together within existing social frameworks produce the forward leaps man can now anticipate. Anarchy, luxuriating in self-indulged isolationism and lost in romantic reverie, cannot produce the diamond-hard poetry this age demands.

—C. L. Sulzberger,
N.Y. Times News Service

November
1969

THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

Inside

President of APHA says nation is not bringing health care to the disadvantaged.

Your Chances of Dying from the Principal Diseases.

Also

Two Book Reviews.

The Solid Waste Disposal Program.

A Modern Version of I Corinthians 13.

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**Guest Editor: Edwin S. Preston,
M.A., LL.D.**

Vol. 84 November, 1969 No. 11

Cover

Three “Squares” backed by the “Establishment” Accomplish The Impossible.

"The Nation

Has Been

Pursuing a

Policy of

Domestic

Brinkmanship

In Health,"

Says

Dr. Lester Breslow

The United States has been pursuing a national policy of "domestic brinkmanship" in dealing with the health problems of racial and ethnic minor-

orities, one of the nation's top public health officials charged here Wednesday night.

"The social policies that we have followed toward these groups still constitute the most shameful aspect of our nation's history," said Dr. Lester Breslow of the University of California, president of the American Public Health Association.

"One can only say that we have been following a policy of domestic brinkmanship, seemingly deliberately, skirting as close to disaster as possible for millions of Americans," Dr. Breslow said.

He was delivering the keynote address at the 58th annual meeting of the North Carolina Public Health Association at Grove Park Inn. His topic was "Trends in Public Health."

Dr. Breslow said he, other physicians and government officials had recently completed a six-day tour of typical environments of minority groups across the country.

"We found that the 20 million Negro people, the 5 million Mexican-Americans and some 500,000 American Indians suffer much more severe health problems because of their conditions of life," Dr. Breslow said.

It would be quite clear to anyone willing to spend six days "looking, hearing and smelling"

such conditions that "it is impossible to achieve health in such environments," Dr. Breslow said.

"So we believe more strongly than ever," he said, "that America has a major task to improve its housing, to establish programs that will truly eliminate gross hunger, to clean up the air and water, and to see that people have decent jobs.

"These are the conditions that are fundamental to good health."

Dr. Breslow said that he and state and federal legislators had been impressed with "what appears to be a spring-up all over the country of little neighborhood groups that are aroused to the point where they are carrying out self-examination and attacking their own local problems."

And local leaders are springing up, he added, to represent disadvantaged people before "the authorities who have the power to do something about the wretched conditions."

He said it would be "highly desirable" for public health officials to work directly with such groups in their attempts to effect needed changes in "social policies."

Another major trend in public health, Dr. Breslow said, has been a shift in the character of health problems.

"Along with the decline in the prominence of diseases like poliomyelitis, tuberculosis and measles," he said, "there has been a decided increase in chronic respiratory disease, lung cancer, coronary heart disease . . . and other fatal diseases associated with chronic alcoholism.

"This list of diseases makes it clear that the major factors in causation lie in individual personal behavior.

"In America, we have attributed too much responsibility to doctors, drugs and hospitals. While these, of course, are increasingly capable of helping people avoid premature death and much disability, it's still true that more fundamental to health is the individual, day-to-day personal behavior."

What this means to public health officials, he said, is that "a new hygiene must be adopted for the latter part of the 20th Century." That new hygiene, he said, must include:

- Safe driving of automobiles and the sensible use of alcohol—if it is going to be used.

- Sensible use of food, good exercise habits and the "avoidance entirely of cigarettes."

- Learning to get along with people inside and outside the family—"the principal element in avoiding emotional and mental disturbances."

Your Chances of Dying From the Principal Diseases

from
Statistical Bulletin
of Metropolitan Life

Because mortality rates have remained virtually unchanged for over a decade—especially among males—the 1967 experience is a good indicator of the current chances of dying from the principal diseases. The risk of dying from these diseases in 5, 10, and 20 years for males and females at selected ages are shown in the table.

The probability of a newborn infant dying within five years—28.9 per 1,000 for males and 22.5 per 1,000 for females—reflects the high level of neonatal death rates. These rates exceed those at age 15 and 30 for males and through age 45 for females.

Mortality rates generally advance with age after the first decade of life, and the chances of dying within a specified period of time increase for any given age as the period of time lengthens. Thus, for men at age 45 the chances of dying increase from about 37 per 1,000 in a five-year period to 283 per 1,000 in twenty years. Correspondingly, the chances of death in twenty years for men rise from 37 per 1,000 at age 15 to 788 per 1,000 at age 65. The chances of death are substantially lower for females than for males at every age and period of years.

The cardiovascular-renal diseases far outrank all other causes of death. This is the outcome of past successes in preventing premature death so that increasing proportions of the population now survive to the middle and older ages when these diseases take their greatest toll. Under current mortality conditions, the chances of eventual death from some cardiovascular-renal disease are about 3 in 5. These chances are higher for women than for men, however, and they rise steadily with advance in age. For example, a newborn male has 564 chances in 1,000 of eventually dying from some cardiovascular-renal condition, compared with 632 per 1,000 for a newborn female. By age 65 these

chances rise to 647 per 1,000 for males and 709 per 1,000 females.

For both sexes combined, arteriosclerotic heart disease accounts for more deaths than vascular lesions of the central nervous system and all other cardiovascular-renal diseases combined. Moreover, in contrast to these other conditions, arteriosclerotic heart disease is a greater threat to males than to females at every period of life. At age 45, the chances of men dying from this cause within ten years are slightly greater than those for women within twenty years. Furthermore, the chances of eventual death from arteriosclerotic heart disease after age 45 are 376 per 1,000 for men, compared with 331 per 1,000 for women.

The chances at birth of eventually dying from a malignant neoplasm (cancer) are 162 per 1,000 for males and 155 per 1,000 for females. For both sexes the probability varies little with advance in age till midlife, when it begins to decrease. Further analysis of the data indicates that the chances of death from cancer of the respiratory system for males are at least 4½ time those for females. By contrast, for all other malignancies as a group, the risk is greater for women till age 65; thereafter it is almost equal to that for men.

Accidents continue to take many lives. Currently, the chances at birth of eventually dying from an accident are 61 per 1,000 for males and 36 per 1,000 for females. Although these chances decrease with age, they still are at least 25 per 1,000 for both men and women at age 65. The greater accident hazard of males prior to midlife is in large measure due to their much higher frequency of motor vehicle fatalities. Past age 65, on the other hand, other forms of accidents pose a more serious threat to women than to men.

For both men and women the chances of dying from pneumonia and influenza have remained virtually unchanged in recent years at approximately 33 per 1,000. Tuberculosis has become a relatively minor cause of death; the present chances of dying from this disease being less than 5 per 1,000 for males and no more than 2 per 1,000 for females.

The experience for diabetes mellitus is noteworthy since it is one of the few causes of death having a substantially higher risk for females than for males. Presently, the chances at birth of eventual death from diabetes are over 24 per 1,000 for women, compared with 14 per 1,000 for men.

A Review Of the Book, "Family Planning"

by Dr. Herbert E. Bill

Required reading for everybody connected with public health is what the little yellow book with the red squares on its papercover ought to be.

Carrying the male-female symbols in the two top red squares, this is the publication entitled simply "Family Planning" which was put out by the American Public Health Association last year.

Showing the subtitle of "A Guide to State and Local Agencies" it was prepared by the Program Area Committee on Population and Public Health.

For those who feel inadequately prepared in the broad field of Family Planning this one hundred and fifty-three page compendium contains all that you will need to know and ends by including lists of more ap-

plicable references than any one who works for a living could ever assimilate.

The text itself has something for everyone right down to the subspecialist's details: for the planner, the promoter, the financer, the administrator, the doctor, nurse, volunteer and aide; the case finder, the health educator, the statistician, the recorder and reporter and the evaluator.

In fact this is one of the two possible criticisms which might be suggested: that there is such a mass of information as might confuse the average reader.

Selective reading, therefore, is the recommendation at least at first. One is advised to pick out the chapters which might be expected to be of particular pertinence to his own situation from the Table of Contents:

Part I—Background

Chapter I: Family Planning:
What it is and how to start
a program.

Chapter II: Fertility and
Health

Chapter III: Public Policy
Chapter IV: Fertility Meas-
urement and Trends

Part II—Program

Chapter V: Family Planning
Methods

Chapter VI: Planning for
Clinical Services

Chapter VII: Educational As-
pects

Chapter VIII: Evaluation of Family Planning Programs

Part III—Appendices

Appendix A: Basic References for State and Local Agencies

Appendix B: Sources of Financial Support and Consultation for Family Planning Activities in the United States

Appendix C: Sources of Information about Training and a Selected List of Training Centers.

After choosing the chapter, then, the suggestion is to scan the subheadings for more specific subjects of personally applicable interest.

Eventually, the rest of the material should fall into place for the individual on rereading.

The second possible criticism is really just a risk: namely, that by the time the reader has restudied the chapters and memorized the subchapters he may lose his original zeal for *doing* something about it. In his new expertise he may tend to forget his ultimate aim which is as straight forward and uncomplicated as the title of the booklet.

That aim, of course, is simply to see that all those women who desire it or who can be convinced of its value are supplied with the best of safe and continuing

contraception and friendly, dignified counselling.

The most important person in the entire program is the satisfied client and the greatest possible number of those is the desired achievement.

The reader is urged to not forget that he himself can think out what he has to do in contributing to that desired achievement. His own conviction, his own enthusiasm are primary attributes. Then the steps essential to the various activities are themselves quite clear and simple, too.

The "Guide for State and Local Agencies" supplies tools, suggests details, gives direction and leaves a lot of room for local initiative.

Persons who actually operate in Family Planning should get valuable new ideas for their own performance.

Those not directly involved should find conviction and a feeling of qualification with which to refer women for contraceptive counselling to the appropriate physician or clinic.

It should not be forgotten, finally, that no matter how complete, well ordered and concisely stated all of this valuable knowledge is, it doesn't really do a bit of good unless enthusiastic people put its information to use.

Guide to Community Control Of Alcoholism

Abstract by Miss Barbara Kahn

This guide by Jay N. Cross, M.P.H., was written with the advice of the Subcommittee on Alcoholism of the Program Area Committee on Chronic Disease and Rehabilitation, APHA.

This reviewer found the guide to be an excellent summary and aid to understanding the problems associated with drinking alcoholic beverages. The need for a coordinated, concerted effort in attacking the problems is stressed throughout.

The complex of approaches to drinking controls are often contradictory and conflicting, the author says, and often result in competition among the groups dealing with the issues surrounding alcoholic beverage consumption. Because of the diversity of values regarding drinking in the United States, formulation of social controls which meet all needs is difficult.

A good discussion of juvenile drinking is included.

Regarding the problem of drinking drivers, legislation is mostly aimed at prohibiting drinking and punishing the drinking driver. To be effective, solution of problem must be derived from programs leading to improved driving and more

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responsible drinking behavior. Laws alone won't accomplish this. "Only groups and organizations with resources for managing problems of human behavior have a chance of success."

"The term *alcoholism* is often used as a label for any form of excessive drinking. This misapplication of the term has led to misunderstanding and confusion in the development of appropriate goals and objectives for alcoholism programs."

Several definitions of alcoholism are described, but for purposes of this guide the definition is that proposed by Keller.

"Alcoholism is a chronic disease manifested by repeated impulsive drinking so as to cause injury to the drinker's health or to his social or economic functioning."

In addition, the term alcoholic is used to refer to those compulsive drinkers who have lost control over the quantity or frequency of their drinking and whose condition cannot be expected to improve unless they completely abstain from the use of alcoholic beverages.

Stages of alcoholic drinking behavior are described.

Alcoholism ranks high among health problems in the United States . . . It is conservatively estimated that there are five

million alcoholics in the United States.

It is interesting to note, however, that North Carolina ranks rather low among the states in its alcoholism rate. The estimated alcoholism rate (according to Jellinek's formula) for women is fourth from the lowest. (Those states with lower rates are Alabama, Idaho, and Utah.) Estimated rates per 100,000 in North Carolina are: men, 3,563; women, 463; and total, 2,013. (Estimated total number of alcoholics in North Carolina is 51,600).

Authors, however, warn that the above figures were taken from national data applied to the states. Extension of such data to local areas may be unwarranted. Other methods should be used in estimating problem in your own community.

The author discusses studies and theories regarding the etiology of alcoholism.

History and present status of community programs are discussed.

Public health programs on alcoholism can be justified, it is pointed out, since they qualify in four major areas:

1. Activities must be conducted on a community-wide basis.
2. Activities deal with preventable illnesses, disabil-

ties or premature death.

3. Activities require organized official leadership.
4. Research must be carried on.

Results of a survey of health workers conducted by the AP-HA regarding their knowledge and opinions about alcoholism indicated that 90% of the respondents considered activity in this field to be a responsibility shared by health departments.

An approach to program planning is described—an approach which would be useful in looking at any health problem.

Four major target areas for program planning are examined: (1) for alcoholics; (2) for providers of service; (3) for prevention; and (4) for opinion molders. Resources and services needed for each are described.

The "schema for developing a community perspective"—that is, a determination of baseline data—is interesting. First, prepare a Base (Overview), describing sociological characteristics of the people, political climate, availability of services, and program and agency relationships. The First Overlay (Facts About Alcoholism) includes data on incidence and prevalence, and existing services. The Second Overlay (Community Concerns) includes such things as overcrowded workhouse, long court dockets, jail

deaths; and pressures such as church positions and "dry" forces. The Third Overlay (Master Plan) describes the resources, services and activities to meet the particular needs of the community.

The suggested roles of various agencies and organizations are discussed. Within local health departments suggestions are made regarding the specific activities that could be carried out by the health officer, the statistician, the community health educator, the public health nurse and the sanitarian.

Program components are described in some detail, pointing out the need for total community involvement and coordination. Community activities include advisory groups, education and training tailored to fit the special needs of selected target emergency services, short-term inpatient services, outpatient services, long-term inpatient services, and halfway houses.

Leadership in initiating and administering programs to control alcoholism will vary from one community to another. The important thing is to get on with the job. Much help in understanding the problems of drinking and of alcoholism and approaches to community action can be found in this 111 page paperback.

IF I speak with the precision of a scholar and acquire the subdued elegance of a television announcer, and have not love for all men, I am but the staccato noise of a riveting machine or the irritation of a dripping faucet.

And if I have the training of a news analyst to predict what will happen tomorrow and understand the Einstein theory and can identify questions, and if I have faith, so as to change the opinions of my neighbors (which in many ways is more difficult than removing mountains), and have not a warm love for people in my heart, I am as interesting as last week's headlines.

If I give all my money to the United Fund Drive and if I push my body to the edge of a nervous breakdown, but have not awareness of God's creative love, I gain nothing.

LOVE is willing to wait a long time and always searches for evidence of goodness in people; it does not push its way through crowds or break into line at the commissary.

Love does not care about recognition on committees, it is not distressed by careless words, nor is it depressed when a fellow worker is successful; love does not rejoice when misfortune comes to a competitor but rejoices in right, no matter who gets the credit.

LOVE is eternally present as the atom; As for predictions of learned men, they will melt away. As for the intricacy of language, the United Nations will surmount that. As for the latest classroom theories, they will vanish like the early morning mists.

Love shows us how little we really know. When I was growing up, I was eager to learn and soon felt that I knew all the answers, but when I became fullgrown, I blushed with the realization of how little I truly knew. For now we see as through a distorted television screen, but then person to person.

What a small fragment I know about the world! But there will come a time when the love of God will show me the world reflected in the souls of people.

So, nuclear mysteries, space exploration, 1970 models of everything, and love are woven into the fabric of life, but the greatest of these is *the creative love of God*. (from I Cor. 13)

*Adapted by Cadets at the Air Academy and used by
Chaplain Porter at the Military Chaplain's Retreat
at Ridgecrest Baptist Assembly 1969*

More About the Longevity of United States Senators

The study of the longevity of United States Senators, reported on in the May issue of the *Statistical Bulletin*, may have given the false impression that service in the Senate since 1930 has been detrimental to long life. This study brought out that Senators who took office between 1860 and 1930 had on the average lived about as long as white males in the general population, but that the average number of years lived by the 144 Senators who took office

between 1931 and 1966 and died by the end of 1966 was significantly shorter than the life expectancy of males in the general population.

The longevity record of the 144 Senators who died before the end of 1966 does not, however, provide a valid indication of the longevity of the entire group of 337 Senators who were first elected to office between 1931 and 1966. The actual average length of life of this group of Senators will not be known until the last of them has died. It is, nevertheless, possible to obtain a better measure of their relative longevity by comparing the total number of years lived by all of them to the end of 1966 with the number of years they might have been expected to live, based on contemporaneous death rates of white males in the general population.

Such a criterion indicates that the 337 Senators first elected between 1931 and 1966 have on the average lived 1.5 years longer to the end of 1966 than white males in the general population born in the same years as the Senators. It is not unreasonable to expect that Senators should on the whole have a better than average life expectancy, considering their socioeconomic status and the fact that prominent men have usually experienced superior longevity.

The Solid Waste Disposal Program

Interview with Sidney H. Usry
by Edwin S. Preston
Over 75 N. C. Radio Stations

1. What is the purpose of solid waste disposal program within the State Board of Health?

Answer:

The purpose of the solid waste disposal program is to promote, plan, and design sanitary landfills for disposal of the waste materials that are generated by our affluent society. Solid waste is defined as all putrescible waste and nonputrescible refuse in solid form. Solid waste includes but is not limited to garbage, rubbish, ashes, incinerator residue, street refuse, dead animals, demolition wastes, construction wastes, solid commercial and industrial wastes, and junked automobiles.

2. Is this a new program of the N. C. Board of Health?

Answer:

No, this is an actual expansion of the garbage disposal program because our

affluent society now has an over abundance of disposables that were not available 10 years ago. The quantity of refuse disposed of per person on a daily basis has more than doubled in the last 10 years. The Sanitary Engineering Division has for many years provided technical assistance to local governmental units in their garbage storage, collection, and disposal. This was started in connection with the vector control as the open garbage dumps were an ideal breeding area for mosquitoes, flies, and rats that are all known vectors of disease.

3. What is the extent of the problem in North Carolina?

Answer:

According to a recent State-wide survey of all communities of 2500 or more population, there is being produced a total of 4,511,000 tons of solid waste annually by a population of 4,500,000. As you can see, this means that for every man, woman, and child in North Carolina, they are producing one ton of waste per person per year. This ton of waste must be stored, collected, and disposed of in some manner. The survey shows that the waste is being disposed of in 56 sanitary landfills and 422

open dumps that are operated by local governmental units. It must be noted that these figures do not touch on the county problem of roadside dumping and wooded areas, as created by the development outside incorporated areas.

4. At the present time what are the accepted or recommended methods of disposal?

Answer:

At the present time, there are three accepted methods of disposal: (1) Sanitary landfill, (2) Incineration, and (3) Composting. The sanitary landfill is probably the most generally accepted method due to the low cost of disposal. It is merely the compacting and covering of the wastes with a layer of earth on a daily basis. Incineration was used by all the major cities in North Carolina at one time but due to the high cost of operation has been abandoned in favor of the sanitary landfill. Composting, a decaying process, is relatively new in this country, but has met with many problems that are created by the amount of materials that will not decay, such as plastics, man-made fibers, etc.

5. Are these methods of disposal considered to be adequate to cope with the dis-

posal of our solid wastes?

Answer:

In my opinion, the present known methods each have certain limitations as to their adequacy. In some areas, where land is available, the sanitary landfill method of disposal can be effectively used. However, in the industrialized and heavily populated areas, the land is not readily available and other methods will be needed, such as the combination of incineration and sanitary landfill. This method would greatly reduce the volume to be placed in the landfill. I think that the real solution to the problem will depend on new technological advances in the field of solid waste disposal.

6. Are there State laws regarding solid waste disposal?

Answer:

The 1969 General Assembly passed the Solid Waste Act that designates the N. C. State Board of Health as the agency authorized to engage in research, conduct investigations and surveys, make inspections, and to establish a State-wide solid waste disposal program. In addition, local boards of health have the authority to adopt ordinances regarding the storage, collection, and disposal of solid wastes.

THE HEALTH BULLETIN
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Raleigh, N. C. 27602

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N.C. DENTAL SOC.
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RALEIGH, N.C.

MORDECAI S

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Printed by The Graphic Press, Inc., Raleigh, N. C.

7. I have heard of the proposed State plan. Will you explain this part of the program?

Answer:

In 1966, the N. C. State Board of Health received a planning grant from the Bureau of Solid Waste, Department of Health, Education and Welfare, for the purpose of making a State-wide survey and the preparation of a State plan. The survey has been completed and the State plan is now being prepared.

8. What assistance is available to local governmental units from your office?

Answer:

This office will be glad to provide technical assistance to the municipalities and

counties through the local health departments, in planning an effective solid waste disposal program.

9. Is there financial assistance available?

Answer:

At the present time, there is no financial assistance available for solid waste disposal. However, there has been introduced in the Congress of the United States an appropriation bill for this purpose, but I do not know the present status of this legislation.

Medicare patients will pay \$8 more on their hospital bills after January 1, 1970 — a mandatory increase.



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

DECEMBER 1969



State Board of Health Elects Officers

Dr. James S. Raper (center) of Asheville was re-elected president of the N. C. State Board of Health at its regular quarterly meeting in Raleigh, December 4, 1969. Dr. Lenox D. Baker (left) of Durham was re-elected vice-president. Dr. Jacob Koomen, State Health Director, continues as secretary to the board. Board members re-elected were Ben W. Dawsey, Veterinarian from Gastonia; J. M. Lackey, Hiddenite; Ernest A. Randleman, Mount Airy; Dr. Joseph S. Hiatt, Jr., Pinehurst and Dr. Paul F. Maness, Burlington. New members of the board are Dr. Charles T. Barker, New Bern and Dr. Jesse H. Meredith, Winston-Salem. Dr. Raper was appointed to the State Board of Health in 1964. He was elected president in 1965. Dr. Baker has served on the board since 1956. He has served two terms as president.

THE HEALTH BULLETIN

First Published—April 1886

The official publication of the North Carolina State Board of Health, 106 Cooper Memorial Health Building, 225 North McDowell Street, Raleigh, N. C. Mailing address: Post Office Box 2091, Raleigh, N. C. 27602. Published monthly. Second Class Postage paid at Raleigh, N. C. Sent free upon request.

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**Address at Annual Meeting of
N. C. Health Council**

By Margaret Dolan

President, National Health Council

Beginning with the passage of the Social Security Act of 1935, each succeeding decade has been marked by an increasing involvement of government in matters of health and medical care. Local, state and federal governments have assumed more responsibility for health care. This has been in response to the increased demand for health services. Concurrently, there has been continued growth in health insurance, pre-payment medical and hospitalization plans, group practice and third party payment plans.

Today, the majority of citizens believe that health care is a basic right of every individual and not a privilege to be enjoyed by those who have the money to purchase it. As one leader has said, "That battle is over". The questions today are: "How shall it be delivered?" "How shall it be paid for?" And "How good will it be?"

A better informed and educated public is not only concerned about the right to health care but it is also determined to see that there is a high quality of health care for all.

Availability, accessibility, and

acceptability are three criteria which are essential for any health service to begin to meet quality standards.

Medical Care Costs Are Rising

With the total cost of medical care reaching \$53 billion a year or 5.9% of the gross national product we can no longer ignore the deficiencies, gaps and inefficiencies of our present system of health care, or, as it has been referred to, a "non-system".

The United States is spending more for health care than any country in the Western world but there is serious question that the care provided in the United States is equivalent in quality to that of some of these other countries. From



1959 to 1968 the cost of living went up 20% while all medical costs went up 45% and daily hospital cost for a semi-private room went up 122%.

In face of this rise in cost it is estimated that 25% of the population receives good quality care, another 50% receives passable care but not as good as it should be, and the remaining 25% receive either inexcusably bad or no care. This situation is intolerable in face of the statement that "American medicine is the best in the world".

All of the expertise, wisdom, creativity, goodwill and resources of both the public and private sector of the health professions and industry must be brought together in a productive and continuing partnership.

National Health Council Needed

The strengthening of this partnership between the public and private sectors makes the need for an organization such as the National Health Council greater now than at any time in its fifty year history. Partnership for health has certainly been the theme emanating from Washington for many months but there has been little leadership for health at the federal level. I believe the voluntary sector must provide the leadership and serve as spokesman to stimulate action for health. The membership of the National Health Council is composed of 70 national voluntary health

and professional associations.

Consumer Participation Is In

Citizen and consumer participation in the decision making processes for health policy at all levels is the "in thing" today whether one is considering comprehensive health planning, neighborhood health centers or new patterns of delivering health services. But consumer involvement or participation poses more questions than answers. How do we identify or define the consumer? How can we have reasonable assurance that once the consumer is identified he is truly representative of consumer interest? How does he become an effective participant in decision making? How do we initiate and maintain channels of communication with consumer groups? How can consumers learn to perform their roles as members of policy groups, advisory boards, and participants in the decision making process?

The 1969 National Health Forum held last March was concerned with the Health Care Problems of the Inner City and for the first time in its history between 150 and 200 consumers of health services residing in the inner city of twelve metropolitan areas across the United States were active participants in the Forum. Some of you attended that Forum and may have come through the experience with the conviction that there is a lot that both health

workers and consumers have to learn about communicating with each other and working together to achieve mutually desired goals and objectives.

For some this was a frustrating, even traumatic and disquieting, experience which left them with a feeling that nothing was accomplished and such a meeting was inappropriate and should never have been planned. Others, equally disquieted, felt the meeting served as a real beginning to bring consumers and health professionals together. I am convinced that ways must be found to close the communications gap that exists between health professionals and a sizeable portion of consumers of health services.

Consumer and Provider Should Be a Partnership

We easily accept the concept of a partnership between the private and public sector of the health industry and I believe we need to accept the partnership that should and must exist between the consumer and provider of health services. The latter is going to be much more difficult to accomplish for we do not always understand or accept our respective jargons, values, hierachial relationships and ways of doing things.

Semantics is only one area which presents obstacles which in the vernacular turns us off or becomes one of our hangups.

The consumer does not al-

ways honor or accept our traditions, fetishes and taboos. They challenge our time honored rituals and prerogatives. We find this hard to take. I believe the consumer does not wish to interfere with the professional and technical decisions of the health service provider but he does feel he has a right to have some voice in determining how, where and under what conditions his health services will be provided.

Consumers Will Participate in 1970 Forum

Again in 1970, the participants in the National Health Forum will include a representative group of consumers and they will not be limited to residents of the inner city. Participants will examine the issues and problems involved in developing health services that are both accessible and acceptable.

I hope the 1970 Forum will provide a continuation of the communication process that was initiated last March, but that it will be a more effective process and that it will develop into a truly meaningful dialogue with both provider and consumer listening, sharing, respecting the point of view of each and coming to a real partnership for improved health services for all citizens in a way that all will be motivated to take appropriate action to improve the health of all our people.

Adoptions in the State by All Licensed Agencies

We do not yet have the printed statistical report on completed adoptions for the calendar year 1968. However, the tabulations have been completed and they show the following:

603 children were placed by county departments of social services.

432 children were placed by the four licensed private child-placing agencies in North Carolina.

The breakdown for the private agency placements is as follows:

Children's Home Society of N. C.	311
Family Services, Inc.	32
Family & Children's Services	40
Catholic Social Services	49
	<u>432</u>

These figures are based on the legal proceedings which have been completed through the final order of adoption and registered by the State Department of Social Services during 1968.

Fire Prevention

For housewives and parents we strongly recommend among many other things:

- Never leave a child alone in a house or building.
- Never have unprotected fireplaces.
- Never use bottled flammable sprays, such as certain hair sprays and insecticides, near fire.
- Always turn pot and kettle handles to the rear of the stove.
- Keep the oven, broiler and burners free of grease.
- Be sure that window curtains or hanging towels do not blow over stove burners or hang too near heaters.
- Never put rags or cloths saturated with furniture polish, paint or wax in closets or cupboards. If you must keep them, put them in covered metal containers.

For the children, do not use lighted candles in your jack-o-lanterns.

For everybody, do not smoke when you are feeling drowsy and never smoke in bed or around any flammable material. When you smoke at home, use large safe ash trays and keep matches and lighters away from the reach of small children.

Eighty to ninety percent of all fires can be prevented.

North Carolina Health Council Holds Successful Annual Meeting



New officers of the N. C. Health Council elected at the 20th Annual Meeting in Durham on December 2 as seen above are: from the left—Dr. John McCain, Wilson, president; Dr. Jacob Koomen, Raleigh, vice president; and John Lockhart, Mount Airy, secretary. Dr. Edwin S. Preston, immediate past president, will serve as a member of the Board of Directors for the next two years. The Annual Meeting was one of the most successful held in the past several years. Some 65 statewide health organizations are members of the Council. Other continuing Directors are: J. Alexander McMahon, Chapel Hill; E. M. Herndon, Durham; and John Ketner, Raleigh.

N.C.

Health

Council

—

Officers

and

Other

Directors

President—

Dr. John McCain, Wilson

Vice President—

Dr. Jacob Koomen, Raleigh

Secretary—

John Lockhart, Mount Airy

Membership—Board of Directors

Term expiring 1970:

Dr. Marc J. Musser
Executive Director
The Association for the
North Carolina Regional
Medical Program
Durham, North Carolina

Term expiring 1971:

Miss Miriam Daughtry
Educational Consultant,
Health Occupations
Department of Community
Colleges
Raleigh, North Carolina
Miss Elizabeth Fink
Assistant Director
Institute for Research in
Social Science
University of North Carolina
Chapel Hill, North Carolina
John K. Lockhart
Administrator
Northern Hospital of Surry
County
Mount Airy, North Carolina

T. Spencer Meyer
Executive Director
United Health Services of
North Carolina
Chapel Hill, North Carolina

Dr. Lee Powers
Director
Division of Allied Health
Programs
Bowman Gray School of
Medicine
Winston-Salem, North
Carolina
Dr. Edwin S. Preston
Immediate Past President

Being an Executive Director

of a

Statewide Voluntary Association

by Marion Foster

Executive Director, N. C. Hospital Association

Address at N. C. Health Council Meeting

My comments will be directed to the voluntary institutional dues paying type of association—contrasted to the public education or fund-raising organization or governmental agency.

I will use the hospital association as the launching point for this discussion since this is the type of organization I work with and know best.

In considering the job of directing, coordinating, or leading an association, we have to look first at the type of institution that makes up that association.

Today's hospitals are far from simple. They are highly sophisticated institutions with expensive equipment and facilities, and reflecting startling progress in medicine over the past fifty years. The practice of medicine has become centered more and more in the hospital environment. Increasingly, communities look to their hospitals as total community health centers.

With hospital progress has come complexities undreamed of a few years ago. As the operation of hospitals becomes more complex, the more diffi-

cult it is for an association to properly represent them.

The hospital association—yesterday's informal discussion, problem-solving, and social group—has become the coordinating organization for a system of complex institutions we call hospitals. Its job is to provide the collective effort that is vital to efficient operation and high quality of care in the individual institution.

Basically, the purpose of the hospital association—like other associations—is to do cooperatively those things which we cannot do as individual institutions—or cannot do as effectively or economically. The association is intended to provide the best mechanism for unified action involving the efforts and resources of many people and institutions.

One of the most important responsibilities of association operation is to gear its program to the needs of the members and allocate time and utilize resources so as to benefit the most members.

This is difficult to do in the health field where the major consideration is public interest. The hospital association, in addressing itself to the problems confronting health care institutions, is deeply involved in a wide range of programs directly affecting the health care of all of our people.

How are these programs accomplished? Hospital associa-

tions, like most voluntary associations, traditionally have been organized to provide as much participation as possible by the membership in policy-making and implementation of programs. We have believed that before an association can speak intelligently for its member hospitals it must know what to speak.

Through the tedious process of council and committee action, the association's position on many of the important questions is defined. These groups supposedly contribute the special knowledge and skill and provide guidance in developing and implementing programs. Theoretically through this process, the association determines what hospitals want, what they will support, what can be accomplished and what, in the long run, is in the best interest of the patient and the public.

Future of Health Associations

Where does the association director and a full-time staff fit into the picture? Today, associations are enterprises that must be treated as organizations dedicated to accomplishment of group goals. This requires that they be adequately staffed and adequately financed; their objectives must be properly defined, and their executives can no longer serve merely as secretaries with no more responsibilities than taking notes and arranging meetings. The executive of an association today

should be one of the most knowledgeable individuals in the field. He is in fact the front man for the organization.

All organizations need to reorganize and restructure themselves at frequent intervals just as we need to buy new clothes from time to time with the change in fashion to give us a sense of renewal. Associations need this sense of renewal too. In my opinion, some dramatic changes are needed in most voluntary associations, if we are to adjust to some of the changes taking place in the health field. The association must keep pace with change and be quick to adjust to new developments.

Initiative of Government

One of the fundamental changes we face is the initiative by big government. Many of the really important decisions affecting the well-being of our health system are now being made in Washington. Associations are preoccupied with implementing national decisions like medicare, medicaid, regional medical programs, comprehensive health planning, training of health personnel, and programs of similar impact. Association executives are spending more time visiting, writing, and calling legislators, reading, digesting and trying to understand federal regulations and interpreting them to our members. The trend toward centralized decision making on

health matters now seems clearly established.

Leadership Role

As I see it, associations, both at the national and state levels, are going to have to play a much stronger leadership role. Both the policy making and action programs will be done with less membership participation and in more expeditious ways. Associations generally have been about as "voluntary" as any type of organization you could find. Not only have we lacked the power to bind our constituency to any set of policies and actions, we have not wanted to do this. The emphasis has been put on broad membership participation — with the wheels grinding slowly in committees, councils, and the board of trustees.

Restructuring Needed

In practice, the association structure which we have on paper and in theory and which has worked fairly well since about 1898 in case of hospitals perhaps isn't going to be the structure we need in the 1970s. The truth is, our many councils and committees are not service, action, or implementation groups. In reality, these groups serve as policy developing groups—not as action groups. There isn't time for busy institutional membership executives to stay away from their jobs and get involved to that extent in association work.

In my opinion, in the future,

both the policy making and the service or implementation aspect of association activity will be done basically by the board of trustees and executive staff with committees being used more as technical or professional advisory groups as needed. We do not need as many members involved in policy making if the board of trustees is a representative cross-section of the membership.

What I have said by implication is that the traditional council and committee structure of the voluntary association tends to diffuse effort and disperse what strength the association might have. Committees sometimes tend to produce internalized problem solving and often become forums for specialized arguments. Evangelists for pet causes can sometimes throw whole association programs out of kilter. The small association can no longer afford this luxury. Our problems have become more complex and we need to concentrate our limited time and resources on them.

Most voluntary associations are structured to grind out policy proclamations rather than programs for action and our structures are such that the policy comes after the fact. We also seem to be structured on the false premise that policy statements are always material to the outcome of the particular issue. It seems that the tradi-

tional association structure with checks and balances at the staff, board, and membership assembly levels with gaps of time in between may be somewhat irrelevant to the problems we now face in the health field. The leisurely pace of this can often make us look pretty foolish.

An alternative for this is for the board of trustees of our organizations to decide what seems worth deciding and then give committees, where appropriate, specific and limited assignments and firm deadlines for getting the job done. Obviously, the board and staff of our associations will have heavier responsibilities and must have more delegated elbowroom on decision making.

There are problems that the voluntary health association must get into in depth, and it is far more important to do battle with some chance of winning on a few selected fronts than it is to try to give a little attention to everything.

Service Organizations

It is already clear that voluntary health associations must move in the direction of more direct services to their members. Broad policy statements on vague issues and beautifully worded "resolutions of appreciation" are rather meaningless to the member who has just sent in a check for several thousand dollars covering dues and assessments for his state and

national association. Health organizations that establish a record of performance of service will be the ones that maintain their power and influence.

I am suggesting that we structure for quite a different kind of health association than we have traditionally lived with. The social club type of organization is obsolete. We must have a much tighter organization with most of the important decision making at the top with much of it being done by experienced, competent staff. This being so, we will have more open channels of communications and more ground rules about responsibility and accountability than in the past.

Summary

To summarize, I think our weaknesses in our voluntary associations are:

1. We are too disjointed, unwieldy, and over-organized. We have the same structure today as when our work had to be done on a purely voluntary basis. Our structure is inconsistent with full-time executive staff.
2. There is a general misconception as to how objectives are implemented. With few exceptions, committees cannot be implementation groups. Committees often look for things to justify their existence rather than having

a definite purpose, objective, or function.

3. Our policy statements often are irrelevant, time consuming, vague, and adopted after the fact. We dwell too much on things which we are too late to change or really influence.
4. We attempt to be all things to all people.

Where should our associations be going in the future. I would see emphasis put on the following:

1. The director, in the future, must be more involved in policy making and program execution.
2. More expertise will be provided by our associations.
3. We will become greater service organizations to our members.
4. Problems will be studied and handled more in depth.
5. We will have more technical and professional persons on our staffs.
6. We will undergo some major structural changes.

These things, however, cannot be accomplished by some simple administrative fiat or re-organizational gimmick. There must be a growth in attitude and philosophy over the years as associations increasingly become more responsible and as the value of their role becomes more widely recognized.

December 2, 1969



Announcement that "Arthritis: Back Stage" has won second prize in the 1968 annual Russell L. Cecil Writing Awards and presentation of the prize was made at a communications media luncheon by Mrs. Robert W. Scott, Honorary Chairman of the North Carolina Chapter of The Arthritis Foundation. In the picture with Mrs. Scott are (left to right): George Bradley, who did the camera work for film; John R. Jordan, Jr., President of the North Carolina Chapter; Verne Strickland, Farm Editor for WRAL-TV and narrator and author of the script; and A. J. Fletcher, Chairman of the Board of Capital Broadcasting Company, operator of Station WRAL-TV.



J. C. Warren, left, is shown accepting a hearty "Thank you" from Joseph E. Barnes, administrator of Raleigh's Rex Hospital, for the gift of a brand new DynaWave machine for the hospital's physical therapy clinic. The machine is a gift from the Wake County Branch of The Arthritis Foundation, of which Mr. Warren is president. The Branch expects to present another DynaWave machine soon to Wake County's Memorial Hospital.

Clay Williams

Named

Public Information

Officer of

State Board

Clay Williams has been named Public Information Officer for the N. C. State Board of Health, according to announcement today by Dr. Jacob Koomen, State Health Director. Williams assumed his new duties on December 1, 1969. He succeeds Hartwell B. Rogers who resigned some months ago.

Williams, a native of Harnett County, has an extensive background in public information, encompassing writing, editing, press releases, radio and television. He was Director of Information for the N. C. Farm Bureau for over three years. He has served with First Union National Bank, Raleigh Savings and Loan Association and First Citizens Bank in public information and public relations capacities.

Williams, who attended Campbell College, is married to the former Evelyn Dearman of Statesville. They have two teenage children.



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Printed by The Graphic Press, Inc., Raleigh, N. C.

State Board Adopts Amendments

Amendments listed below were adopted December 4, 1969, by the N. C. State Board of Health. Copies of the Rules and Regulations, including amendments, may be obtained by addressing requests to the N. C. State Board of Health (division listed in italics), Raleigh, N. C., 27602.

- Amendment to Rules and Regulations for Protection Against Radiation (*Sanitary Engineering Division*).
- Amendments to Rules and Regulations Relative to Sanitation of Scallops (*Sanitary Engineering Division*).
- Resolution authorizing Murdock Center, Butner, to per-

mit camping and recreational activities on Lake Butner, the water supply for Murdock Center (*Sanitary Engineering Division*).

- Resolution authorizing City of Rocky Mount to permit controlled fishing and other recreational activities on the Tar River Water Supply Reservoir (*Sanitary Engineering Division*).
- Regulations Governing Authority to Perform Blood Alcohol Tests (*Epidemiology Division*).
- Revision of Rules and Regulation for the Licensing of Nursing Homes, Intermediate Care Facilities—Type A., Intermediate Care Facilities—Type B, Boarding Homes for the Aged and Infirm in Combination Homes. (*Personal Health Division*).



